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An Exploration of Male Batterers' Perceptions of a Standardized Batterers' Treatment Program

Dionne Lynn Spooner
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Dionne Spooner

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Review Committee
Dr. Dorothy Scotten, Committee Chairperson, Human Services Faculty
Dr. Teresa Tirrito, Committee Member, Human Services Faculty
Dr. James Castleberry, University Reviewer, Human Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

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Abstract

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MSW, Florida State University, 2006

BSW, Minot State University, 1997

Dissertation Submitted in Partial Fulfillment

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Abstract

The focus of this hermeneutic phenomenological, qualitative study was to gather an in-depth understanding of the lived experiences of male batterers participating in a standardized Duluth-model batterers' treatment group. The study had three main goals: (a) to understand the experience of male batterers participating in a standardized male batterers' treatment program, (b) to improve the treatment being provided to male batterers, and (c) to improve services to those impacted by domestic violence. Results from previous studies indicated that treatment for male batterers is ineffective and inconsistent and that the treatment provided, regardless of framework or modality, has little or no effect on recidivism. This study advances understanding of male-batterer treatment by exploring treatment from the perspective of those who receive it. The study included 9 men currently participating in a Duluth model batterer's treatment program in Minot, North Dakota. From the study results, 3 overall themes emerged: (a) overall group experience, (b) facilitators, and (c) Duluth model. Results indicated that the current delivery of the treatment is not effective for batterers. Findings suggested that the facilitators played an essential role in the treatment program. Findings further suggested that participants believed the Duluth model could be an effective treatment modality for batterers. Study findings may inform a more responsive and comprehensive treatment modality for male batterers. Such an intervention may improve service delivery for both batterers and victims as well as improve recidivism. These changes may result in positive social change for not only families caught in the cycle of violence but also for every sector of society.

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Dedication

I dedicate this work to my children: Coy, Hope, and Keagen. I hope that the time, energy, and dedication I found to complete this journey will continue to inspire my children to reach their own educational endeavors. I also want to dedicate this study to all those individuals impacted by domestic violence who have had the courage to make positive change in their own lives.

Acknowledgments

I would like to express my sincere appreciation to my committee members: Dr. Dorothy Scotten and Dr. Terry Tirrito. I would like to provide a special word of thanks to Dr. Scotten for always providing a reassuring nudge when I found myself stuck or when I became stuck in my own thoughts. I would also like to thank Deborah Olson and Vicki Michels who were always willing and able to listen to my dilemmas and challenges with the process, and yet encouraged me to continue on the journey.

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Chapter 1: Introduction to the Study

Introduction

Domestic violence (DV) is a major public health concern and global human rights issue, yet the voices of batterers have not been included. The treatment provided to male batterers evolved merely out of necessity as an alternative to incarceration in the 1970s, when professionals began to formally recognize DV (Catlett, Toews, & Walilko, 2010; Corvo, Dutton, & Chen, 2009; Hague & Sardinha, 2010; Jewell & Wormith, 2010; Mallaly, 2011). The problem is that a group of women's rights activists created the first model, the Duluth Model, as an educational model to re-educate men in relationship equality, not as a therapeutic-treatment program (Eisikovits & Bailey, 2011). In addition to the educational nature of the program, the treatment of male batterers has been modified many times using various modalities and still has failed to prove efficacious (Arias, Arce, & Vilarino, 2013). Rather, therapists continue to treat batterers using loosely confined parameters without ever including the voice of the participants, the batterers. The issue of male batterers' treatment must be placed in the larger context of DV to be fully understood.

Domestic violence is an issue that one in four women will experience at some point in their lifetime (Centers for Disease Control and Prevention [CDC], 2010). The largest percentage of female victims is between the ages of 18 and 34 years of age (Catalano, 2012). Although the feminist movement initially identified DV as a women's rights issue in the 1970s, it was later identified as a major health concern in the 1990s and remains a major public health concern today (Adelman & Correa de Azevedo, 2011; Brown, 2008; Chan & Cho, 2010; Hague & Sardinha, 2010; Kanno & Newhill, 2009;

Kruse, Sorensen, Bronnum-Hansen, & Helweg-Larsen, 2011; Stith, McCollum, & Rosen, 2011). Domestic violence against women is not only a public health concern but also a global human rights issue (Abramsky et al., 2011). The cost of DV exceeded $12 million a year in the United States (Chan & Cho, 2010), whereas domestic-violence victims' medical costs were 122% higher than those of never-abused women (Bonomi, Anderson, Rivara, & Thompson, 2009). In addition to the physical, emotional, and financial impacts on women, who comprise the majority of victims, their children also are impacted.

Children who are exposed to DV experience physical, psychological, emotional, and behavioral challenges that continue into adulthood (Fortheringham, Dunber, & Hensley, 2013; Katz, Hessler, & Annest, 2007; Meltzer, Doos, Vostanis, Ford, & Goodman, 2009; Sturge-Apple, Davies, Cicchetti, & Manning, 2012). Domestic violence in the home not only alters children's brain development, but also their physiological regulatory abilities (Sturge-Apple et al., 2012). Exposure to DV is a precursor to posttraumatic stress disorder (PTSD) in youth (Margolin & Vickerman, 2011). Abuse negatively impacts children's peer relationships, beginning as early as the elementary years (Katz et al. 2007). Although DV directly impacts children, it also affects businesses, the community, and society at large.

The average cost to businesses per day is $68,987,493 for all domestic-violence victims (Chrisler & Ferguson, 2006); figures do not include indirect costs, thereby markedly underestimating the impact (Chan & Cho, 2010). Domestic violence is a leading cause of homelessness (Baker, Billhardt, Warren, Rollins, & Glass, 2010): as many as 22 to 50% of women's homelessness directly results from DV (Franklin, 2011). Globally, DV is a substantial social issue (Abramsky et al., 2011; Fanslow & Robinson,

2010; Kanno & Newhill, 2009). According to the CDC (2010), every minute, 24 individuals become victims of DV. In the State of North Dakota alone, arrests for aggravated assaults increased nearly 8% between 2010 and 2011, and nearly half of the homicides in 2011 related to domestic-violence (North Dakota Attorney General, 2014). According to the North Dakota Council on Abused Women's Services (2013), more than 4,000 new victims of DV sought services in 2011 and nearly 5,000 new victims sought services in 2013.

The average cost per assault ranges from $548 to nearly $3,000 in the United States (Chrisler & Ferguson, 2006; Kruse et al., 2011). Similarly, costs around the world are both tangible and intangible (Chan & Cho, 2010). Annual medical costs range between $700,000 in New Zealand to over $12 billion in the United States (Chan & Cho, 2010). In addition, abused women tend to use not only emergency-department care, but also radiology, pharmacy, and psychiatric care (Bonomi et al., 2009). Finally, DV is the foremost call made to law-enforcement agencies across the country (Sun, as cited in Spooner, 2013).

This study focused specifically on one aspect of DV: male batterers in treatment. The male batterers studied here have been court ordered or voluntarily enrolled in a standardized male batterers program, the Duluth model. Although the standardized male batterers program is offered throughout North Dakota, this study looked specifically at batterers participating in a program in Minot, North Dakota. This chapter includes a review of the current challenges surrounding male batterers' treatment, the significance of treatment for male batterers, the history of male batterers' treatment, the research

questions, the theoretical framework, nature of the study, assumptions and limitations of the study, and the operational definitions used.

Statement of the Problem

To fully understand the complexity of male batterers' treatment, one must identify the multiple variables impacting treatment. Individuals who commit acts of DV are typically identified as batterers; however, these individuals are as diverse as the communities from which they originate (LaViolette, 2009). Analysis of batterers began as early as the 1970s when researchers attempted to develop and establish classifications of batterers, as well as the violence and injuries that resulted from the battering (LaViolette, 2009). However, stakeholders (researchers and healthcare providers) have identified no one typology of batterer (Day, Chung, O'Leary, & Carson, 2009; Gibbons, Collin, & Reid, 2011; LaViolette, 2009; Wallach & Sela, 2008). Stakeholders must consider men's assumptions and attributions of batterers' treatment (Wallach & Sela, 2008), batterers' psychological profiles (Gibbons et al., 2011), ethnic differences, and the readiness of batterers to address their battering behavior (Alexander, Morris, Tracy, & Fry, 2010). These combined factors clearly impact the current recidivism rates of batterers.

Recidivism is one of the variables used to measure treatment success (Cooper, Durose, & Snyder, 2014; Olver, Stockdale, & Wormith, 2011). Recidivism of batterers and the continuing cycle of violence are of concern not only for victims and their children, but also for the criminal justice system, mental health professionals, and communities at large. General recidivism rates have remained between 40 and 60% over the past 30 years for all criminal offenses (Hughes & Wilson, 2002, p. 1). Although

approximately 20 to 40% of male batterers reoffend annually (Tollefson & Gross, 2006), the highest risk offenders are most likely to drop out of treatment and also to recidivate (Olver et al., 2011, p. 1). Of violent offenders, 72% were rearrested within 5 years of release and nearly 75% of all offenders were arrested within 3 years of release (Cooper et al., 2014). The reentry of offenders into society is "a significant concern for the criminal justice system, offenders, mental health professionals, and society as a whole" (L A. Phillips, 2010, p. 10).

Despite abundant literature related to the negative impacts that DV had on children, victims, and even society, literature related to batterers was far more limited. Despite significant research related to recidivism of criminals in general, recidivism specific to batterers was sparse. Longitudinal research demonstrated that batterers' treatment has failed to demonstrate efficacy (Corvo, Dutton, & Chen, 2008), which is the problem I chose to study, whereas batterers' treatment programs require little accountability (Day et al., 2009). The core of the problem is the lack of input from the batterers themselves regarding treatment (Tollefson, Webb, Shumway, Block, & Nakamura, 2009). An additional challenge is the lack of a clear theoretical or conceptual framework to guide the treatment of offenders. I was unable to identify any literature related to what the batterers themselves actually thought about the most frequently used batterers' treatment modality: the Duluth model.

The Duluth Domestic Abuse Intervention Project (DAIP) established the first male batterers' treatment model in 1981, later recognized as the Duluth Model (Corvo et al., 2009). The Duluth Model is a 27- to 36-week standardized curriculum that seeks to hold men accountable using a group psychoeducational framework. The Duluth Model,

or some variation, is the most commonly used court-sanctioned treatment for male batterers in the United States and Canada (Corvo et al., 2009).

The purpose of the study was to explore the perceptions of male batterers currently participating in a standardized Duluth Model batterers' treatment program about their treatment experiences. I considered the batterers to be experts in the field of DV and asked them to provide feedback regarding the effectiveness of the current modalities of treatment. The data collected from this study aid understanding of treatment from a batterer's perspective, including the identified modules experts believe are appropriate, as well as the modules that are ineffective. The information allowed conceptual themes and frameworks to emerge, aiming to improve treatment planning and programming, a possible reduction in recidivism, and relationships among families.

Background

Providers do not use evidence-based practice in the treatment of male batterers, yet considered evidenced modalities a cornerstone of practice for psychologists, social workers, and mental health clinicians (Corvo et al., 2009; Smith, 2011). A significant amount of research on DV and male batterer intervention is unused in treatment planning or interventions (Corvo et al., 2008). Long-term research and evaluation of the Duluth Model demonstrated little to no effectiveness (Aymer, 2008; Corvo et al., 2009; Huss, Covell, & Langhinrichsen-Rohling, 2006). In a meta-analysis of batterers' treatment programs, effect sizes were quite small, with reoffending rates ranging between 20 and 40% (Babcock, Green, & Robie, 2004). Results from numerous studies demonstrated little to no effect size, high-recidivism rates, and little overall effectiveness in court-mandated intervention models (Corvo et al., 2008). Recidivism following treatment

remains between 28 and 90% (Gover, Jennings, Davis, Tomsich, & Tewksbury, 2011). The National Institute of Justice has significant data that is simply unused, thereby adding to the lack of clarity regarding treatment outcomes (Corvo et al., 2008). The current political framework surrounding batterers' treatment is void of any accountability for agencies (Aymer, 2008; Corvo et al., 2009; Mankowski, Haaken, & Silverglied, 2002). Each state has a certifying agency tasked with approving or denying intervention treatments, yet they do so without any empirical data to support the decision (Corvo et al., 2009). In addition, ethical issues arise for practitioners as a result of these methods (Corvo et al., 2009).

Professionals may face challenges in trying to abide by their professional code of ethics while implementing the Duluth model, due to its lack of demonstrated efficacy (Corvo et al., 2009). In addition to ethical issues (Corvo et al., 2009), the Duluth model has methodological flaws (Gover et al., 2011; Levesque, Ciavatta, Castle, Prochaska, & Prochaska, 2012). High dropout rates and noncompletion of programming only further skews the findings (Levesque, Driskell, Prochaska, & Prochaska, 2008).

Most treatment programs offered to batterers reported using a standardized model such as the Duluth model (Levesque et al., 2008), whereas few if any programs specifically tailored their program to meet the individual needs of the participants (Levesque et al., 2012). After reviewing program data from 1975–2013, researchers found that the majority of programs reported using the Duluth model or some similar type of psychoeducational modality (Arias et al., 2013). Findings indicated that regardless of which modality was provided to batterers, recidivism rates were statistically significant (Arias et al., 2013).

In North Dakota, a collaborative among law enforcement, DV programs, and mental health professionals formed in 1994 to develop and implement a standardized male batterers' treatment program (North Dakota Council on Abused Women's Services, 2013). The group became known as the North Dakota Adult Batterer Treatment Forum. They modeled the treatment program after several other state programs that used the Duluth model. The group implemented the standardized treatment in 1997 and has not modified it since. The current treatment program consists of 2-hour weekly sessions delivered over a 27-week period. The group offers the program throughout the state, facilitated by two individuals who must be licensed or must have extensive domestic-violence training.

Framework

Counselors use no consistent conceptual framework to treat batterers; rather, they combined, altered, or developed several different frameworks to create a treatment program for batterers. The work of feminists had a significant impact on the development of the first batterers' treatment programs in the 1970s (Corvo et al., 2008). The unstructured group-therapy model resulted from the work of mental health professionals alongside women's advocacy groups (Mankowski et al., 2002). The unstructured group-therapy model was one of the first group models used to treat batterers (Mankowski et al., 2002)

The unstructured group-therapy model used a psychodynamic perspective in which the facilitator took a nondirective approach (Mankowski et al., 2002). Psychoanalytic theory guided the model and allowed for group participants to look at childhood experiences, traumatic history, and emotional responses to aid in individual

growth. The group focus was on peer support, growth, and skill development with an individual emphasis. Proponents of this approach believed it allowed for not only skill development, but integration in participants' cognition. The length of treatment was typically 18 months (Mankowski et al., 2002). Although the unstructured-group model used a more individual focus, the Duluth model is more educationally based with a focus on confrontation.

Although the unstructured-group model and the Duluth model focused on participants' growth and skill development, they differed in methodology. Both approaches used social-learning theory to teach new skills to participants (Mankowski et al., 2002). However, the focus of unstructured-group therapy was individual growth, accomplishing psychological development through the use of psychoanalytic theory; in contrast, the Duluth Model focused on patriarchy in a political context (Aymer, 2008; Corvo et al., 2009). In addition, the Duluth model used an operant learning theory with heavy emphasis on criminal behavior and confrontation (Arias et al., 2013; Corvo et al., 2009). The unstructured model used group support to achieve self-paced learning objectives through mutual support, whereas the Duluth model had rigid directives aimed at reeducating participants in more egalitarian relationships (Arias et al., 2013).

In the 1990s, domestic-violence advocates asserted the psychodynamic perspective of the unstructured-group therapy model did not hold batterers accountable (Mankowski et al., 2002). Advocates argued that the basic anger-management approach did not address the basic components of DV, patriarchy, and control of women (Mankowski et al., 2002). During this same time period, researchers began working to identify not only batter typologies but the underlying psychology of DV (Aymer, 2008;

Chiffriller, Hennesey, & Zappone, 2006). Practitioners and researchers attempted to use psychopathology to understand and explain the violence (Aymer, 2008; Corvo et al., 2009; Mankowski et al., 2002).

Corvo et al. (2009) indicated explanatory and intervention research should be incorporated into the redesign of the current model. Three separate explanatory theories have emerged: (a) feminist/sociocultural, (b) social learning, and (c) psychological (Corvo et al., 2009). Psychological theories have demonstrated the strongest descriptive and predictive association not only for battering, but for criminal behavior in general (Corvo et al., 2009; Day et al., 2009; Huss et al., 2006; Mankowski et al, 2002). The main focus when using the psychological theory is on individual cognition, with several outside variables impacting a batterer's choices (Day et al., 2009). Interestingly, the philosophical assumptions of the psychology theory are contrary to the very premise of the Duluth model (Day et al., 2009).

The present study sought to approach the conceptual framework using a bottom-up approach in which the data obtained from the batterers themselves allowed for emergent themes to develop. Using a hermeneutic phenomenological approach allowed for the actual experiences of batterers participating in a Duluth-model treatment program to emerge and elicit greater understanding. The information provided allowed for a broad description from batterers themselves. Mental health professionals tasked with providing services to this population and criminal justice professionals may use the data. Through the qualitative process, I anticipated the data would provide a more concise picture of what batterers themselves believed should comprise future treatment modalities. Although previous researchers used several different conceptual frameworks, the present

study was not bound by one framework; rather, it incorporates the concept that researchers have used several frameworks. The study was driven by the research questions presented to the batterers and the batterers' responses.

Research Question

The research question selected allowed research participants to openly share their thoughts about the Duluth model of treatment as a treatment modality for battering, as well as the specific components of the model. The research question developed for the study was: What is the experience of a male batterer participating in a standardized male batterers' treatment program based on the Duluth model?

Nature of the Study

I selected a qualitative hermeneutic phenomenological methodology to answer the research question. The phenomenological approach allowed participants' voices to be heard and understood. A phenomenological study allows several individuals to describe their lived experiences surrounding a particular phenomenon (Creswell, 2013). Phenomenological studies allow those who have lived an experience to ascribe meaning to it (Patton, 2002). The data provided by participants allowed for emerging themes or concepts to evolve. It is important for offenders' experiences to be uncovered and understood (Kenemore & Roldan, 2006). Stakeholders need increased knowledge that addresses battering from a holistic perspective (Corvo et al., 2008; Moore, 2011; Polaschek & Collie, 2004). The integrity of treatment is necessary not only for the clinician but also the participant, as it allows for transparency and accountability (Day et al. 2009). Although researchers have used structured risk-assessment instruments extensively in studying recidivism, they have not provided clinicians with the succulent

detail that comes from offenders themselves (Coid et al., 2009). A hermeneutic phenomenological study allowed understanding what batterers' treatment experience was and how batterers interpreted the treatment. I considered and rejected other qualitative approaches.

Grounded theory may have provided an equally appropriate modality for this phenomenon, as it would have allowed for a theory to emerge from the data, but was deemed to be beyond my current skill level. Grounded theorists not only look at a shared experience, but also generate a theory from the data collected (Creswell, 2013; Patton, 2002). Grounded theory would require simultaneous data collection and analysis (Creswell, 2013; Patton, 2002). In addition, the grounded-theory approach requires a large number of participants, which was available (Creswell, 2013). Although grounded theory appeared to be too complex for me, the narrative approach appeared too narrow to answer the research question developed.

Narrative research is ideal when the researchers seeks to uncover and describe one individual's chronological experience of an event or events (Creswell, 2013). The narrative approach focuses on one rich story from a single batterer, but this would not have answered the questions related to this study. I considered case study research, but deemed it may have been problematic to obtain multiple sources of information from participants, and the research question sought the lived experience of the phenomenon. Case studies require not only one specific case, but using multiple sources for in-depth understanding (Creswell, 2013).

I did not consider ethnography, as the research question sought information unrelated to a cultural sharing group, nor did it require immersion in their lives (Creswell,

2013; Patton, 2002). Qualitative research provides several approaches to address a study, and although many of them could have been employed in this study, I identified the phenomenological approach as the most appropriate. A future study may allow researchers to use a grounded-theory approach.

Assumptions and Limitations of the Study

All studies have assumptions and limitations that must be addressed. Assumptions assisted in the development of the framework and methodology for the research study. One basic assumption was that DV is predominantly perpetrated by men on women. An additional assumption is that the patriarchal orientation of society has not only influenced but impacted treatment options for male batterers. In addition, DV involves not only physical but psychological and emotional control over a victim. Finally, I deemed participant responses to be honest responses.

One limitation of the current study is that I selected only one small regional sample of participants for the study, and the sample does not represent the general population. In addition, only participants who were willing to volunteer participated. A methodological limitation is that the phenomenon under study is presented ex facto, and therefore, participants' responses represent perceptions and recollections of the events, which can alter the information provided. Another limitation of the phenomenological approach is that researcher bias may impact the study, the data collected, and analysis. I have spent nearly 20 years working in the field of DV; however, the majority of that time was spent working with victims receiving services as a result of DV. An additional limitation is that I assumed participants understood and responded honestly to the research questions. Although researchers can peruse documents such as arrest reports and

intake assessments to verify crimes committed by individuals, I took verbal responses in this study at face value, and based findings on those responses. Another limitation was the short amount of time for the interviews, which may have prevented information from coming forth. A final limitation is my gender—female—which may have impacted not only the willingness of participants to participate, but also their responses. The research participants were all men who were court ordered or volunteered to participate in a male batterers' treatment program, thereby creating a potentially adversarial relationship, particularly if the batterer's victim was a woman.

In reporting all assumptions and limitations of the study, readers have an honest account of the study, including the strengths and weaknesses. I took steps to assure authenticity as I was the primary research instrument. I kept written field notes of all meetings, interviews, and analysis sessions. These notes included not only the spoken words of participants, but observations and personal reflections as well. I shared notes of the interviews with interview participants to create a member check of the data, and used external auditors to assure validity, thereby triangulating the data.

Significance

The significance of the present study lies in its contribution to understanding the experiences of male batterers participating in treatment. This information will be particularly beneficial to professionals who provide services to batterers, including those work in the criminal-justice system, mental health professionals, and treatment providers. North Dakota standards have not been updated since 1997, and statistics indicated that not only is DV still prevalent in North Dakota, but increasing. Results of the study may also be of interest to policymakers who are tasked with funding treatment programs. In

addition, the findings are of utmost importance to society, as it continues to address this major health concern (Clements & Holtzworth-Munroe, 2008). The significance of this study is the contributions it makes to not only improving services to batterers in North Dakota, but also to the field of DV. Through improved services to batterers, services to victims and children can also improve, resulting in healthier families. The combination of improved results for batterers and victims results in positive social change. The results of DV can be devastating to the children, victims, and batterers, and also to extended family members, employers, medical professionals, social-welfare professionals, criminal-justice systems, and communities and societies at large.

The importance of findings from the batterers themselves is essential to truly understand the treatment experience. The professionals tasked with providing treatment to batterers gain valuable knowledge when it is provided directly by clients (Wallach & Sela, 2008). DV was brought to the attention of clinicians and the court systems in the 1970s and remains a national concern today, not only to individuals directly impacted, but every other sector of society as well. The United States runs the largest and most expensive criminal justice system in the world (Staples, as cited in Kenemore & Roldan, 2006). Furthermore, the federal system releases as many inmates each year as it takes in (Kenemore & Roldan, 2006).

This study provides knowledge to professionals tasked with developing and implementing batterers' treatment, as well as improving current treatment modalities. A great deal of research has identified barriers and rates of recidivism in batterers; a gap in research exists in the actual experiences of the batterers participating in batterers' treatments (Cobbina, 2010; L. A. Phillips, 2010; Wallach & Sela, 2008). This acquired

knowledge adds to the current research concerning batterers' treatment, and in addition, aids professionals who work to rehabilitate batterers. This population is an ideal target for the helping professions whose aim is to create social justice (Kenemore & Roldan, 2006).

Implications for Social Change

This study allowed male batterers' voices to be heard regarding batterers' treatment. Findings from the study allow the North Dakota Adult Batterers Treatment Forum to hear from actual participants. Based on these findings, the North Dakota Adult Batterers Treatment Forum may elect to use this information to modify, change, or improve the current treatment programming.

Findings from the study could allow for a more effective, evidence-based treatment program for male batterers that is created jointly with batterers. Treatment for batterers must improve with emphasis not only on evidence-based practice but also incorporating information provided by batterers (Corvo et al., 2009; Day et al., 2009; L. A. Phillips, 2010). Study findings could also potentially be used for future research, which could expand and further understanding, as well as treatment development for batterers. This study has the potential to change and improve current treatment modalities to decrease recidivism, improve treatment outcomes, and reduce DV incidents in society.

Operational Definitions

Operational definitions of DV must be clearly defined to accurately report study findings, draw appropriate conclusions, and inform research (Abramsky et al., 2011; Lipsky & Caetano, 2009). For the purposes of this study, I used the following definitions:

Domestic violence (DV): The physical, sexual, psychological, and/or emotional abuse perpetrated by a male against his current or previous female spouse or significant

other. According to the CDC (2010), intimate partner violence is another term used to describe this phenomenon, but the CDC included female perpetrated violence as well. Physical abuse associated with DV includes pushing, punching, kicking, hitting, and any other form of physical aggression. Sexual abuse, in the context of DV, includes any sort of forced sexual act by the perpetrator upon the victim. Psychological or emotional abuse includes any sort of verbal threat intended to exert control over the victims or limit their freedom.

Batterer: This term defines a man who has perpetrated DV on his current or former spouse or significant other. Perpetrator and DV offender or criminal are all used in the literature (Chiffriller et al., 2006; Corvo et al., 2009; Gover et al., 2011; Levesque et al., 2012; Maiuro & Eberle, 2008; Smith, 2011; Tollefson, Gross, & Lundahl, 2008).

Batterer Treatment Program: As defined by the North Dakota Adult Batterers Treatment Standards Forum (2011):

> Treatment consists of three areas designed to provide batterers with the education, therapy, and crisis management components that they would need in order to choose to stop abusive and violent behavior. Treatment provides the tools for participants to change; whether they choose to change the behavior remains their responsibility. The mission of the ND forum is to develop standards for the treatment of batterers in North Dakota that will create a network which promotes the safety of victims and assists batterers in stopping abusive behavior (p. 21).

The Batterers Treatment Program used in this study was a standardized batterers treatment program offered at Lutheran Social Services (LSSND) in Minot, ND.

Criminal record: On the demographic questionnaire used in this study (see Appendix A), criminal record was one of the domains used to collect data. Participants completed the questionnaire to describe their criminal history, including history of arrests and convictions for crimes related specifically to DV. I cross-referenced this information with the criminal reports that the program had available on participants. I was not concerned with non-DV crimes.

Summary

Domestic violence is a considered not only a major public health issue but also a global human rights issue (Abramsky et al., 2011). DV produces immediate, and long-term consequences for victims, children, and batterers including implications related to family dysfunction, mental health issues, criminal behavior, and involvement in multiple social welfare programs. DV produces significant costs to families, communities, and societies.

Batterers' treatment research began in the 1970s; however; recidivism rates have continued to demonstrate little or no efficacy from treatment (LaViolette, 2009). Recidivism rates have remained between 40 and 60% (Tollefson & Gross, 2006), Results of a meta-analysis showed that recidivism rates from 35 different programs averaged 51% (Olver et al., 2011).

The current study examined one standardized male batterers' treatment program offered in Minot, North Dakota, through the perspective of the male batterers themselves. In this study, I sought to gain knowledge from the batterers themselves about the current treatment programming in order to improve treatment outcomes and reduce recidivism. Chapter 2 provides a review of the literature related to DV batterers and the treatment

modalities offered. Chapter 3 describes the research design and approach, setting, sample, instrumentation, and analysis methods used. Chapter 4 reviews the results of this qualitative study, whereas Chapter 5 presents a discussion of the significance of the study and offers recommendations for future research.

Chapter 2: Literature Review

Introduction

The goal of the proposed research study was to explore the effectiveness of the Duluth model male-batterer treatment method from the perspectives of male batterers. To understand how clinicians developed the Duluth model for treatment of male batterers and the current effectiveness of this treatment model, it is necessary to evaluate the history of male-batterer literature in the larger context of the DV movement. True intervention cannot occur until professionals understand the perspectives of batterers, and consequently, the complexity of treating male batterers (Wood, 2004). An evaluation of treatment options for male batterers cannot be completed without a thorough understanding of the DV movement, which began in the 1970s (Wood, 2004). Without the beginning emphasis on attempts to aid battered women, the complex interactions associated with all those involved in the battering system would not have evolved. Thus, understanding the role of the DV movement also enhances understanding of the ways men develop and maintain their identities as male batterers. To compile and examine all relevant research related to the experience of male batterers participating in male batterers' treatment, it is necessary to understand not only the evolution of the DV movement, but also the ways in which men develop and maintain their identities.

The DV movement began in the 1970s worldwide as a response to the need to build shelters for women escaping from violence; however, those involved realized that children, batterers, mental health professionals, and the criminal-justice system were equally essential to the DV movement. In addition, women initiated and directed the DV movement that began in the 1970s, and this feminist perspective has continued to

influence the overall DV movement. A review of the literature showed that the treatment of batterers evolved out of necessity. It was feminist directed. Treatment continues to lack continuity and efficacy. The literature provided the framework for my study.

Domestic Violence against women is not only a public health concern but also a global human rights issue, with rates of perpetration against women ranging from 15% in Ethiopia to over 70% in Japan (Abramsky et al., 2011). In the United States alone, more than 25% of women will become victims of DV at least once in their lifetime (CDC, 2010). In addition, 50% of all female victims of DV will lose a job because the violence is associated with $3 to $5 billion in absenteeism costs and $10 billion in healthcare costs (Brown, 2008). Healthcare costs associated with DV were in excess of $19.3 million in the United States alone per 100,000 women in 2008, with individual yearly costs ranging between $4,000 and $10,000 (Bonomi et al., 2009).

Children who are exposed to DV at home are at a higher risk for exposure and developing emotional and psychological conditions, including physical abuse, psychological abuse, neglect, addiction, truancy, DV, and PTSD (Katz et al., 2007; Margolin & Vickerman, 2011; Sturge-Apple et al., 2012). In addition, children who witness DV, regardless of age, continue to be under recognized and undertreated (Alderson, Westmarland, & Kelly, 2013; Katz et al., 2007; Margolin & Vickerman, 2011). The issue of violence and male-identity development is not only under examined, but is also a critical issue during adolescence (Pleasants, 2007).

Law enforcement's response to DV calls in the 1960s and 1970s was guided by a philosophy that interpersonal conflicts in the home should remain there (White, Goldkamp, & Campbell, 2005). In the 1980s, influence from the DV movement pressed

for a more active criminal-justice response that included mandatory arrest of the batterer (Shields, 2008; Sun, 2007). Despite this change, domestic calls remain the foremost call made to law enforcement (Sun, 2007), indicating that arrests alone are insufficient to reduce rates of battering. Concurrent with the DV movement's advocacy for mandatory arrest was the recognition of treatment options for batterers, and an emphasis on a more community-based response to DV. This attempt at solutions led to the development of the DAIP in 1980 (Corvo et al., 2009; Day et al., 2009). The DAIP, commonly known as the Duluth model, became the standardized batterers' treatment program, but as the literature demonstrated, it has continued to lack efficacy. In addition, DAIP has been modified by those implementing it. The literature demonstrates that clinicians originally intended the Duluth model to provide male batterers with an educational model; however, mental health providers adapted this model as a therapeutic intervention without any evidence to support the practice. The lack of any national oversight, coupled with a loose definition of what batterers' intervention programs (BIPs) actually offer, illustrate the need for more research into male batterers' treatment (Corvo et al., 2008, 2009; Day et al. 2009). Recidivism rates for male batterers following any form of BIP since 1975 continues to demonstrate that treatments are ineffective (Arias et al., 2013). Recidivism emerges not only in treatment outcomes, but also in arrests. The number of violent offenders in the U.S. prison system has continued to grow, with assault (DV) rates rising from 7.9 to 10.3%, and sexual assault rates rising from 8.2 to 12.4% between 1991 and 2011 (Carson & Golinelli, 2012). In addition, parole violations for these crimes have more than doubled since 1991 (Carson & Golinelli, 2012).

The following comprehensive literature review identifies and supports the importance of the current study and the potential for improving male batterers' treatment modalities. The first section of the chapter describes the literature-search strategy. Subsequent sections review the variables that comprise batterers' treatment. As indicated earlier, understanding how treatment options for male batterers have arisen from the DV movement is necessary to gain insight into how and when the focus on these individuals arose. Thus, the review begins with an historical review of how the DV movement began, focusing specifically on the evolution of services offered to male batterers. I then consider specific treatment modalities offered to batterers. A review of the development of male identity follows this section. To provide a holistic view of the study, I consider the victims and children who are directly affected by the violence, followed by contemplation of the role of the criminal-justice system in this phenomenon.

Literature-Review Research Strategy

To compile and examine all relevant literature, I used several strategies. First, I compiled all relevant literature addressing male batterers' treatment from several scholarly online research databases including Academic Search Premiere, PsycARTICLES, Thoreau, ProQuest Central, and Google Scholar. In addition to using large research databases, I employed criminal justice, social work, psychology, and health science databases. Keywords used in the process included batterer, battering, batterer intervention, batterers treatment, domestic violence perpetrator, domestic violence treatment, intimate partner violence, and intimate partner treatment. Scholarly and peer-reviewed articles were utilized during this process. Initial searches focused on articles published within the past 5 years; however, evolutionary and seminal literature

provided a historical and contextual framework for batterers' treatment, as well as for the overall DV movement. Finally, I included state and national reports in the search using the same keywords and topics. Using these resources, I compared and analyzed key articles based on conceptual and theoretical frameworks, population characteristics, and relevance to the topic. The review describes study strengths and limitations, gaps in the literature, and ethical concerns.

The review of the literature on the implications of DV on victims, children, employers, housing, and criminal justice clearly demonstrates that the effects of DV are negative, costly, and far-reaching. In stark contrast, the review of the literature regarding batterers demonstrates far less research emphasis on understanding this component of the battering system. Thus, the male-batterer literature is sporadic in a number of studies with results that are inconsistent and inconclusive. Research reports continue to demonstrate that DV is the foremost healthcare concern facing women across the globe (Abramsky et al., 2011; Mallaly, 2011). The costs to society associated with DV are significant (Brown, 2008). The costs and effects on the criminal-justice system can be traced to the 1960s and remain a significant issue today (Shields, 2008; Sun, 2007). The gap in the literature is the voice of the male batterers and, more specifically, what batterers believe needs to be addressed in batterers' treatment. The issue of effective treatment of batterers emerged in the 1970s and is still relevant today. Of nearly 20,000 batterers who have completed treatment between 1975 and 2013, less than 5% remained violence free, according to official reports (Arias et al., 2013). Official reports only paint a limited and often skewed view of treatment outcomes, as many batterers and victims do not report the violence, and many who initially report the violence fail to follow through with services or

recommendations. Recidivism rates following batterers' treatment range from 15 to over 65% (Jewell & Wormith, 2010; Olver et al., 2011; Rosenberg, 2003; Tollefson & Gross, 2006; Waldo, Kerne, & Kerne, 2007).

In this framework, I identified the gap as well as the framework for the current study. To complete a comprehensive yet exhaustive review of the phenomenon of batterers' treatment, the approach described in the literature review strategy connected the articles selected. The chapter is organized in chronological order beginning with the evolution of male batterers' treatment arising in the DV movement, through current male-batterer treatment options today. The review includes the beginnings of the DV movement, then moves to the treatment approaches offered to address DV BIP, victims, children, and the criminal-justice system, with emphasis on the conceptual framework and the progression of the research over time. In this framework, themes evolved from the literature that indicated a qualitative study with participants currently enrolled in a male batterers' treatment program would add valuable data to the current gap in the literature.

Conceptual Framework

The DV movement arose in the 1970s when activist Erin Pizzey began a battered-women's shelter in Chiswick, England, and wrote about the experiences of DV victims in her first book, *Scream Quietly or the Neighbors Will Hear* (Walker, 2002). The actions taken by Pizzey sparked the beginnings of DV research at universities, as well as movements across the globe. The United Nations recognized the significance of DV in its 1979 Convention on the Elimination of All Forms of Discrimination against Women (Hague & Sardinha, 2010); however, the reports from the 1979 Convention never

mentioned DV (Mallaly, 2011). It was not until 1993 that the United Nations Convention created and ratified the Declaration on the Elimination of Violence against Women, and included specific language not only identifying DV, but also holding all member states accountable for instituting measures to address the violence (Hague & Sardinha, 2010; Mallaly, 2011). The U.S. DV movement began in the late 1970s, and although it initially focused solely on providing shelter and protection for victims and children, it quickly evolved to include the male perpetrators of the violence (Campbell, Neil, Jaffe, & Kelly, 2010; Catlett et al., 2010; Corvo et al., 2009; Day et al., 2009; Jewell & Wormith, 2010; Lehrner & Allen, 2008). Although women may also be perpetrators, this specific study follows the national trends that continue to indicate that men comprise the vast majority of batterers (Oehme & O'Rourke, 2012).

Historical Framework

The DV movement led to mental health professionals in the 1970s needing to evaluate how to provide services to these men (Mankowski et al., 2002). The initial treatment provided by the mental health professionals focused on marital stress, conflict, and mutual accountability, typically conducted in a couple format (Mankowski et al., 2002). A group model quickly replaced the couple approach because of the feminist movement's pressure to provide more accountability and economically feasible options for batterers (Corvo et al., 2008; Day et al., 2009; Dutton & Corvo, 2006; Mankowski et al., 2002). The initial group-therapy model provided batterers with unstructured group therapy (Eisikovits & Bailey, 2011; Mankowski et al., 2002; Saunders, 2008), whereas the first true treatment provided to batterers used the psychoeducational group format commonly known as the Duluth model (Day et al., 2009; Dutton & Corvo, 2006; Gondolf

2011). The unstructured-group-therapy model and the psychoeducational model have some important similarities and differences.

The unstructured-group-therapy model did not have a set or preplanned focus; rather, different topics emerged from interviews conducted with group members by a trained mental health professional (Mankowski et al., 2002; Saunders, 2008). Findings from a meta-analysis indicated that since the mid-1980s, nearly 50% of the BIPs in the United States and abroad used an unstructured-group-therapy model, whereas the remaining 50% used the Duluth model (Saunders, 2008). The unstructured-group-therapy model is a psychotherapy or cognitive-behavioral model because it uses talk therapy to identify thoughts or thought processes that cause disruptive behavior (Arias et al., 2013; Gondolf, 2011; Mankowski et al., 2002).

Batterer Intervention Programs

A group of advocates in Duluth, Minnesota (Corvo et al., 2009; Day et al., 2009), developed the DAIP in 1980. The DAIP, commonly known as the Duluth model in the literature, is a psychoeducational approach that focuses on power and control purposely executed by men over women in a patriarchal society (Corvo et al, 2009; Eisikovits & Bailey, 2011; Mankowski et al., 2002). The Duluth model emerged in response to the overuse of the unstructured-group-therapy model, which DV advocates believed does not hold men accountable; instead, it minimizes and downplays the purposeful nature of the abuse perpetrated by batterers (Corvo et al., 2009; Day et al., 2009; Mankowski et al., 2002). Another significant component of the Duluth model is its community-coordinated response to the criminal-justice system (Corvo et al., 2008, 2009; Day et al., 2009; Eisikovits & Bailey, 2011; Mankowski et al., 2002).

The Duluth model was specifically established to allow men who batter an alternative to jail time (Corvo et al., 2009); in contrast, advocates contend the coordinated approach intends to assure victim safety (Day et al., 2009). However, the Duluth model represents a coordinated community intervention (Corvo et al., 2009; Day et al., 2009). In addition, the ultimate goal of the Duluth model was to not only to reeducate men, but also to transform them into nonviolent and egalitarian partners (Eisikovits & Bailey, 2011). The Duluth model assumes that society encouraged and socialized men to be the dominant ones in the society, whereas society socialized women to be submissive; therefore, the model places heavy emphasis on reeducation (Corvo et al., 2008, 2009; Day et al., 2009; Eisikovits & Bailey, 2011; Mankowski et al., 2002).

The Duluth model comprises eight central themes: intimidation; economic abuse; emotional abuse; coercion and threats; isolation; male privilege; minimizing, blaming, and denying; and using children (DAIP, n.d.). These eight central themes form the Power/Control Wheel, considered a trademark of the Duluth model (Corvo et al., 2009; Mankowski et al., 2002). In a study of batterers, one theme was presented every 3-weeks for a total of 24 weeks of programming (Mankowski et al., 2002). After the batterers received education on the methods of power/control, leaders reeducate them to use the "Equality Wheel" (DAIP, n.d.). The eight central themes of the Equality Wheel include negotiating/fairness; economic partnership; unthreatening behavior; respect; trust and support; honesty and accountability; responsible parenting; and shared responsibility (DAIP, n.d.).

It is important to note both similarities and differences between the two major approaches (Mankowski et al., 2002). One of the most significant differences between the

two models is the unstructured-group approach, which allows batterers to openly discuss their own pasts, including their own victimization. In contrast, the Duluth model indicates that allowing this type of open discussion only reinforces and justifies the abusive behavior of the batterer (Arias et al., 2013; Corvo et al., 2009; Mankowski et al., 2002). Despite significant differences in the focus of each model, the implementation of these models by facilitators is quite complex and typically blends both models (Arias et al., 2013; Corvo et al., 2008, 2009; Day et al., 2009; Dutton & Corvo, 2007; Gondolf, 2011; Mankowski et al., 2002; Saunders, 2008). While Mankowski et al. (2002) and Saunders (2008) identified one model as an unstructured group therapy model, Corvo et al. (2008, 2009), Dutton and Corvo (2007), Day et al. (2009), and Gondolf (2011) identified the model as a cognitive-behavioral therapy (CBT) model (Beck, 1976). Several researchers have highlighted the complexity of batterers' treatment, its modality, and implementation by facilitators as critical elements of which we need to be acutely aware, as they affect the assessment and evaluation of the programming.

Dutton and Corvo (2007) cited fault with Gondolf (2007) naming the Duluth model as "Duluth-CBT" due to the Duluth model and CBT being fundamentally different. Beck (1976) developed CBT based on the assumption that faulty thoughts cause psychological problems that a therapist can best address by developing a strong therapeutic bond with the client. Thus, the pair address and correct the faulty thinking in this relationship. In addition, group participants are not only allowed, but also encouraged to discuss their own past traumas, which may include victimization (Arias et al., 2013; Dutton & Corvo, 2007; Mankowski et al., 2002; Saunders, 2008). Cognitive behavioral theory is not mentioned in the Duluth Model manual (Dutton & Corvo, 2007); rather, the

Duluth model is based on a Marxist philosophy in which “thought reform” addresses patriarchy, male privilege, and domination (p. 660). According to Dutton and Corvo, it is erroneous to assume that all men believe in male domination and interpersonal violence, as only 2% of U.S. men report believing it is acceptable to use physical violence to keep a wife/girlfriend in line; therefore, the Duluth model uses a very targeted educational component that does not attempt to explain why men believe in male privilege, but rather reeducates them on equality in relationships. This important educational component appears to be significant. Mankowski et al. (2002) reiterated Dutton and Corvo, supporting the irrelevance of understanding individual male perpetrators’ thought processes in traditional Duluth-model programing. Although Dutton and Corvo criticized Gondolf for combining CBT and the Duluth model, several other researchers presented their findings of BIPs, indicating no distinction between approaches.

Saunders (2008) reported that BIPs might include group therapy, individual therapy, group and individual therapy, and some couple counseling; however, Saunders did not indicate which therapeutic modalities were actually used. Day et al. (2009) reported similar findings; however, they found that the Duluth model was the most common approach used in the United States. Aguirre, Lehmann, and Patton (2011) concurred with Day et al., indicating that the Duluth model is the most common approach utilized in North America. Arias et al. (2013) reviewed several different types of BIPs using a similar method to that of Saunders, indicating that the most effective programs combined a psychoeducational approach with CBT, yet provided no indication of whether the psychoeducational program was based on the Duluth model. Researchers in

the field have repeatedly cited this lack of clarity between treatment modality and actual implementation.

Corvo et al. (2008), Dutton and Corvo (2007), Mankowski et al. (2002), and Saunders (2008) indicated different modalities; and loosely monitored the actual implementation of the modalities. Corvo et al. (2008) indicated that the only oversight of male-batterers' programs occurred at the state level by state-certifying agencies, which simply allowed or denied different BIPs while not requiring any type of data to support such decisions. Corvo et al. (2008) concluded that BIPs are not only unregulated at the state level, but also fail to comply with basic models of efficacy required of virtually all therapeutic modalities. Dalton (2009) supported Corvo et al. (2008), indicating that no national standards exist, and no national surveys have been completed since the 1980s. According to Corvo et al. (2009), the current policy framework surrounding batterers' treatment was based on an outdated profeminist framework that sought to hold men accountable, regardless of their individual differences, with no therapeutic foundation; this framework continues in use today. The lack of implementation of prescribed modalities among the facilitators themselves further highlighted the lack of accountability by treatment programs. Although the Duluth model and CBT appear to be the prominent modalities, clinicians use several other modalities.

Alternative Treatments

Aymer (2008) disagreed with the Duluth model's focus on patriarchy and sexism, and instead used an individual psychodynamic approach to address a batterer's psychosocial functioning. Aymer based this approach on the theories of attachment, social learning, and object relations. Aymer's case study demonstrated that the individual

psychodynamic approach was effective in reducing marital hostility and improving the individual's psychosocial functioning. A significant limitation of this approach is that a single case study severely limits its applicability to the general population. In addition, individual treatment is always an option, regardless of what is available, thereby providing little in the way of knowledge regarding DV dynamics.

Levesque et al. (2008) disagreed with the Duluth model and CBT as a uniform approach for everyone; therefore, Levesque et al. assessed the effect of the transtheoretical model of behavior change (TTM) to increase client-treatment congruence. TTM, developed by DiClemente and Prochaska (1998), provides an integrative approach to address intentional behavioral change. Levesque et al. proved the effectiveness of TTM in decreasing addictions, smoking cessation, and weight management. Nearly 90% of batterers who participated in TTM reported it was useful and improved their thought processes (Levesque et al., 2008). The study included only 33 participants, which limited its applicability to the general batterer population. Alexander et al. (2010) expanded the Levesque et al. study by comparing 528 male batterers enrolled in programs using either the TTM or a cognitive reeducation model. Alexander et al. highlighted that the TTM entails tailoring the programming to the level of motivation of the participant, which is essential in treating batterers. One important factor was not only what a batterer reported, but also what the victim reported in treatment outcomes. The challenge was that only 25% of the victims completed follow-up reports (Alexander et al., 2010). Several findings emerged from the study. Only batterers who were "unwilling to change" improved after the TTM intervention. In addition, victims reported more positive effects across the board for batterers who attended TTM.

McMurran (2009) also studied the effect of TTM on batterers; however, McMurran found no reduction in violence.

Mills, Barocas, and Ariel (2013) assessed a restorative approach and found that the standard approaches to DV batterers' treatment were ineffective. Mills et al. assessed the Circles of Peace (CP) program used in Arizona to treat batterers. The CP approach focuses on restorative justice and restoring the individual and family. The CP approach includes the victim and batterer, but may also be conducted only with the batterer. Mills et al. looked at 152 cases of which 50% included victim's responses. Findings indicated that DV arrests were lower at 6, 12, 18, and 24 months posttreatment; however, the only stage that showed significant improvement was at 12 months posttreatment. An additional finding was that no CP participants indicated DV incidents occurred while enrolled in the CP program (Mills et al., 2013). The lack of clarity among and in treatment programs is compounded by the many criminal-justice programs. The legal system relies not only on assessment, but also on feedback from BIP directors about participants' risk for reoffending, victim safety, and program completion.

BIP Facilitators

Even when a BIP indicated an offering of one specific type of modality, facilitators acknowledged they struggled to adhere to one specific approach, and more often than not, would combine reeducation with elements of CBT to engage group participants (Dutton & Corvo, 2007; Mankowski et al., 2002). In the United States, 2,500 programs currently operate, with more than 60% of them unaffiliated with any specific agency (Dalton, 2007). These findings highlight the ambiguity that exists in the actual treatment provided, not only to batterers, but also to those who provide the treatment.

Many programs fail to identify which modality clinicians use or whether they reported a combination of approaches (Dutton & Corvo, 2007; Mankowski et al., 2002; Saunders, 2008).

BIP directors play a pivotal role in batterers' treatment (Weisz et al., 2012). In a national survey with BIP directors, Dalton (2007) found that 20% of BIP directors indicated the programs altered their programming based on participants' screening criteria. In addition, over half of the program directors cited they only received income from client fees, with an average fee of $23.00 per session, thereby creating not only a necessity for the program, but also potentially creating a financial hardship for participants (Dalton, 2007). Although Weisz et al. (2012) indicated that BIP directors make clinical assessments, Dalton found that less than 50% of the BIP programs reported using professionals: 30% reported using student interns and 20% used volunteers. BIP facilitators lack training across the United States and also lack any sort of national standard (Stover & Lent, 2014). The apparent lack of any professional standards, training, and financial support adds to the ambiguity that surrounds batterers' treatment.

Training

DV comprises two main components—the cycle of violence and issues of power and control—which are two main components of the Duluth model (Stover & Lent, 2014). Understanding both of these components is important for therapeutic outcomes for victims and batterers. However, no standards of cross training exist among victim and batterer service providers, which creates a disconnection in service provision and contradicts the Duluth model's focus (Stover & Lent, 2014). Between 60 and 80% of men who batter are also fathers (Israel & Stover, 2009; Salisbury, Henning, & Holdford, 2009;

Stover & Lent, 2014). In addition, Bureau of Justice statistics between 2005 and 2010 revealed that more than 75% of victims reported being assaulted by the same batterer. Victims and batterers not only reunite, but must also juggle parental responsibilities. Devaney (2009) highlighted the high frequency with which those involved in child welfare encounter DV, yet most child-welfare workers have no training in DV. The lack of training and cross training with those who directly encounter DV is further compounded by a lack of required education.

Currently, no state educational standards exist for victim advocates or batterer treatment providers (Dalton, 2007; Stover & Lent, 2014). Although state agencies certify batterers' treatment programs, the actual requirements for program facilitators range from a 1-day training and no educational degree, to a master's degree and extensive specialized training (Corvo et al., 2009; Stover & Lent, 2014). According to the ND Adult Batterers Treatment Standards, group facilitators must have a North Dakota human-service related license, experience working with perpetrators and with victims, 1 year of direct clinical work with victims, and a minimum of 50 hours of direct clinical work with perpetrators (North Dakota State Treatment Board Standards, 1997). Typically, the North Dakota batterers' program requires two facilitators, one male and one female; however, if only one facilitator is available, they must meet all of the above requirements (North Dakota State Treatment Board Standards, 1997). However, research on the actual qualifications of facilitators was limited.

Few formal studies describe BIPs (Dalton, 2007); however, more than one-third of programs responding to a survey identified using student interns or volunteers with no mention of what type of degree, if any, facilitators were required to have. Rosenberg

(2003) interviewed batterers who reported that group cohesion was the most important factor of the group experience, indicating that perhaps the actual qualifications of facilitators may not be as important as researchers once thought. However, Weisz et al. (2012) highlighted that most facilitators not only facilitate the group, but also assess recidivism, successful completion of the program, and the batterers' level of risk in returning to the community. In addition to the need for facilitators to assess risk at the end of the program, the need exists for facilitators to evaluate risk throughout the program.

Many facilitators are uncomfortable reporting risk due to the limited amount of information they have available to them; thus, they tend to assess risk conservatively (Weisz et al., 2012). In addition to assessing risk, facilitators must assess cooccurring disorders, such as substance abuse (Dalton, 2009), and must assess the safety of the victim and mental health of the batterers (Huss et al., 2006). Previous researchers found a correlation between substance abuse and DV (Dalton, 2009); approximately half of men in either substance abuse or batterers' treatment experienced cooccurring substance abuse and battering (Thomas & Bennett, 2009). Researchers have also identified other mental health conditions.

Gibbons et al. (2011) asserted that approximately 50% of the men who participated in DV programming met diagnostic criteria for a personality disorder. Walsh et al. (2010) found that male batterers tended to display more antisocial personality traits and psychopathology. In addition, Clements and Holtzworth-Munroe (2008) found that, compared to nonviolent men, men who engaged in DV expressed aggressive cognitions, particularly spouse-specific aggressive cognitions, more frequently. Smith (2007) found

that men who batter have lowered emotional intelligence, which is an important variable in treatment programming. Gibbons et al.'s findings indicated that most batterers in their study met criteria for passive-aggressive, avoidant, depressive, and dependent personality disorders, whereas anxiety disorder was the most common Axis I disorder. Huss et al. (2006) found that antisocial men engaged not only in more acts of DV, but also in more severe acts of violence. Ethnicity was an additional variable discussed by researchers.

Olver et al. (2011) identified ethnic minority status as a predictor of poor treatment outcomes, as well as dropout and recidivism rates. Gondolf (2007) indicated the lack of culturally sensitive material influenced treatment outcomes; however, Gondolf found that culturally sensitive materials did not significantly improve outcomes. In 2012, the Federal Bureau of Investigation Hate Crime statistics reported that more than 50% of offenders were White and 23% were Black, with the remaining offenders being of different ethnicities, replicating Gondolf's findings.

Recidivism

Recidivism of treated participants is one of the most significant measures used in mental health treatment to determine treatment efficacy. Criminal justice researchers and evaluators have equal interest in predicting and evaluating treatment outcomes (Hanson & Wallace-Capretta, 2004; Rhodes, 2010). Findings regarding recidivism of male batterers have been a point of significant concern for researchers, particularly in the DV field, due to the wide variety of findings and opinions that have emerged. In addition, the sensitive and intimate context in which DV occurs necessitates a thorough understanding of recidivism in this population (Hanson & Wallace-Capretta, 2004). The literature paints

a skewed, ambiguous picture of treatment effects ranging from no effect to maximum effect, given the complexities of participants.

The most common approach to studying the effectiveness of DV programs has been posttreatment recidivism (Sartin, Hansen, & Huss, 2006). The issue of recidivism in DV is complex, not only because of the underreporting of the DV, but also because many times, the only actual data that can be used hails primarily from the legal system rather than victims or batterers (Sartin et al., 2006). Less than 10% of assaults are reported to law enforcement (Fleury-Steiner, Bybee, Sullivan, Belknap, & Melton, 2006; Sartin et al., 2006; Ybarra & Lohr, 2002). Of victims, 60% talked about the violence with someone; however, the majority reported it to informal supports, such as family (Fanslow & Robinson, 2010). Reasons for reporting violence to formal sources, such as police or shelters, included fear of death, life-threatening injury, and concern for children (Fanslow & Robinson, 2010). Interestingly, Bureau of Justice annual statistics showed that since 1994, intimate partner violence reports decreased by over 60% in the United States (Catalano, 2012). An additional concern is the high dropout rate of batterers, which further skews posttreatment recidivism (Jewell & Wormith, 2010). To acquire a more accurate picture of recidivism, Arias et al. (2013) included couples reports and official reports in their meta-analysis.

Researchers have often been singularly focused rather than objectively exploring actual recidivism; therefore, Arias et al. (2013) reviewed 22 separate studies conducted between 1975 and 2013 that included 18,941 batterers. Studying all treatment modalities, including dialectical behavioral therapy (DBT), CBT, and individual therapy, Arias et al. found that recidivism rates based on couple reports were significantly higher compared to

official reports. Although many programs demonstrated some positive effects, they were not statistically significant. Whereas Arias et al. considered several different modalities, Day et al. (2009) focused just on DBT.

Day et al. (2009) found that whether therapist offered DBT alone or in combination with another treatment modality, results demonstrated a lack of efficacy. Babcock et al. (2004) reported recidivism rates of 21% per police reports to 35% per partners' reports following DBT. Regardless of how recidivism is measured, the treatment modality must be able to demonstrate a statistically significant effect (Day et al., 2009). Although Tollefson and Gross (2006) concurred with Day et al. that the current treatment provided was not efficacious, they argued that the current treatment must not be abandoned; rather, it should be improved.

In addition to the observational risk provided by clinicians, structured risk assessments are used to predict recidivism (Rhodes, 2010; Urbaniok et al., 2007). Coid et al. (2009) and Hanson and Wallace-Capretta (2004) listed some of the more common assessments used with criminals: the Psychopathy Checklist—Revised (PCL–R; Hare, 1991, 2003); the Historical, Clinical, Risk Management–20 (Webster, Douglas, Eaves, & Hart, 1997); the Risk Matrix 2000–Violence (Thornton et al., 2003); the Violence Risk Appraisal Guide (VRAG; Quinsey, Harris, Rice, & Cormier, 1998); and the Offenders Group Reconviction Scale (Copas & Marshall, 1998; Taylor, 1999). Actuarial assessments demonstrated greater effectiveness in predicting recidivism compared to clinical judgment (Coid et al., 2009). In addition, certain assessments have demonstrated greater predictive accuracy with women, whereas others have shown greater predictive accuracy with men (Coid et al., 2009).

The Violence Risk Appraisal Guide

Clinicians have used and validated the VRAG with various criminal populations, including male sex offenders (Seto, 2005), male psychiatric patients, people with mental disorders (Kroner, Stadtland, Eidt, & Nedopil, 2007), and non-North American populations (Hastings, Krishnan, Tangney, & Stuewig, 2011). The VRAG was found to be an effective tool in treating domestic offenders through cross validation (G. T. Harris et al., 2003). G. T. Harris, Rice, and Quincy (1998) and Rice and Harris (1995, 1997) studied the VRAG and its application extensively with not only domestic, but also sexual offenders. Although Harris et al. (2003) reported the effective use of VRAG with this population, these findings were not found in other studies in the field. In addition, the VRAG requires extensive knowledge of the batterer's history, which may not always be available or provided by the batterer (Hilton et al., 2004; Seto, 2005). Seto (2005) argued that multiple tools should be used to provide the most accurate risk of recidivism; Rhodes (2010) argued that no evidence suggests that combining tools is more effective.

Hilton, Harris, Rice, Houghton, and Eke (2008) compared the VRAG to the Hare Psychopathy Checklist (PCL-R) and found that the PCL-R was better at predicting recidivism and the occurrence, frequency, and severity of battering. Walters, Knight, Grann, and Dahle (2008) concurred with Hilton et al. (2008), and added that while the PCL-R's personality facet is the strongest predictor of future recidivism, other affective, interpersonal, and lifestyle factors can increase understanding of each individual's recidivism profile. Although these tools may aid clinicians and other mental health professionals in making clinical decisions, they do not aid in providing a more efficacious

treatment to batterers. In addition, many actuarial risk assessments require not only training, but also financial support.

Victims

DV continues to be the foremost concern facing women at local, national, and international levels (Herbert, 2008; Hovmand & Ford, 2009; Kanno & Newhill, 2009). Women know their assailants in 70% of all violent crimes (Bureau of Justice Statistics, 2010). Victims of DV experience trauma similar to that of victims of hostage and torture (Howard, Trevillion, & Agnew-Davies, 2010). In addition, victims are at a higher risk for depression, PTSD, suicide, sleeping and eating disorders, and alcohol and drug abuse. This complex mental health picture is observed among DV victims worldwide (Howard et al., 2010).

One issue that appears to be of significant concern is not only whether victims report acts of violence to the legal system, but also whether they perceive the services provided them as effective. In the Fleury-Steiner et al. (2006) study, women reported that nearly half the time someone in the system discouraged them from seeking justice. African Americans are more likely to seek law enforcement to assist them whereas Caucasians tend to seek informal services to navigate through the system (Hollenshead, Dai, Ragsdale, & Scott, 2006). Nearly 60% of cases of suspected abuse and neglect reported in the United Kingdom included DV, and in all of the reported cases, the social worker placed all responsibility for child(ren)'s safety with the mother (Devaney, 2009). Many times, child-welfare workers have no advanced training or knowledge of the dynamics of DV, despite becoming the primary service providers to the family (Alderson et al., 2013). Batterers were more likely to be arrested and prosecuted when a third party

reported the violence (Hollenshead et al., 2006). International services continue to be grossly inadequate (Hague & Sardinha, 2010). These data demonstrate the challenges victims face in seeking assistance. Additionally, the treatment currently offered to batterers does not include the victim, although many batterers and victims will remain in contact because of their children or their relationship (Stith et al., 2011). Furthermore, the Duluth model is predicated on the safety of the victim and community accountability for the offender.

Restorative Approach

VanWormer (2009) reported that women were dissatisfied with the current approach to DV, as it failed to meet their needs. Restorative justice is an appropriate alternative to traditional BIP, as it allows for the woman's voice to be heard as well as to reach a resolution (Mills et al., 2013; VanWormer, 2009). A restorative-justice approach used in Arizona was just as effective as traditional BIPs (Mills et al., 2013). In a meta-analysis, researchers highlighted that couples' treatment demonstrated a reduction in recidivism, as did restorative-justice programs such as CP (Eckhardt et al., 2013).

Couples Therapy

Those who opposed couples' therapy argued that its premise lies on joint responsibility of an issue, which contradicts traditional DV treatment (Stith et al., 2011). In addition, a therapist might encounter challenges in maintaining neutrality when working with a victim and offender. However, in contrast, not honoring a victim's wishes of reunification with her partner is equally disempowering to not acknowledging the abuse. A benefit of couples' treatment is that both partners are learning and practicing new skills at the same time, allowing them to grow, eliminating the need for

manipulation. In addition, couples therapy enabled the therapist to tailor the treatment to the specific needs of each couple (Stith et al., 2011).

Regardless of where a clinician stands on the issue, therapists must adhere to strict guidelines when conducting couples therapy with partners who have experienced DV (Stith et al., 2011). The first guideline is that the therapist conducts a thorough assessment of each partner independently (Stith et al., 2011). It is necessary to conduct independent assessments when working with batterers (Dalton, 2007; Huss et al., 2006; Stover & Lent, 2014; Weisz et al., 2012). The second guideline requires therapists to undergo specialized training in DV and in assessing danger and violence (Corvo et al., 2009; Dalton, 2007; Gibbons et al., 2011; Huss et al., 2006; Stith et al., 2011; Stover & Lent, 2014). The third guideline, taken directly from the Duluth model, recommends clinicians work collaboratively with the community of DV service providers to offer a coordinated community response (Stith et al., 2011). Stith et al. (2011) emphasized that Couples who have experienced DV do not participate in traditional couple's therapy; instead, each individual partner participates in 6 weeks of individual therapy. Subsequently, the therapist assesses each person for appropriateness to begin and participate in a conjoint session with a partner. In addition, Stith et al. suggested using a "stable third" or a mutually agreed upon stable supportive family member who can provide support, not only during the conjoint session, but also after the session. This type of supportive person is also used in restorative-justice programs, such as the CP program in Arizona (Mills et al., 2013). Finally, Stith et al. highlighted that safeguards must be in place while working with couples who have experienced DV. Once again, this is a primary component of the original Duluth model.

Children

Between 60 and 80% of men who batter are also fathers (Israel & Stove, 2009; Salisbury et al., 2009; Stover & Lent, 2014); millions of children are impacted by DV annually (Spilsbury et al., 2007). Children who were exposed to DV, even at early ages, struggled to develop healthy peer attachments and emotional competence, as well as to adjust behaviorally to external stimuli (Katz et al., 2007). Researchers clearly linked children's exposure to DV to mental health conditions, such as anxiety and depression, and it increased the likelihood that these children would experience DV as adults (Devaney, 2009; Katz et al., 2007; Margolin & Vickerman, 2011; Spilsbury et al., 2007). Spilsbury et al. (2007) completed a study comprising 687 children of DV, and found that children's perception of threat and control correlated with clinical trauma symptoms and behavioral issues. In addition, covictimization of the child(ren) increased not only the level of trauma symptoms, but also the behavioral issues (Spilsbury et al., 2007). Children not only experience trauma, but can also develop PTSD (Margolin & Vickerman, 2011). DV creates some unique challenges to PTSD because the violence is ongoing and the child(ren) are developing both psychologically and emotionally at the same time. Challenges associated with developing PTSD accompany increased risk for addictions and life-long relationship challenges. Although DV also affects older children, both during and following the events, young children are more likely to show signs of the trauma (Margolin & Vickerman, 2011).

A mother's attachment to her fetus already is altered in utero when experiencing DV (Levendosky, Bogat, & Huth-Bocks, 2011); furthermore, this altered attachment is shown 5 years post birth in that the mother–child attachment is marked by insecurity,

inconsistency, and dissociation by both the mother and child (Levendosky et al., 2011). Sturge-Apple et al. (2012) looked at cortisol levels in toddlers in response to parental violence and maternal emotional availability. Findings showed that toddlers who saw parental violence had reduced cortisol output, and the mother was emotionally unavailable because of her own trauma. Sturge-Apple et al. study revealed the complexity of child development and attachment in the context of DV. Although children's own emotional and psychological development are affected, they are trying to balance ongoing contact with their fathers.

Half of men who participated in batterers' treatment reported they had not told their children they were participating because they believed the children were too young to understand or would be embarrassed (Alderson et al., 2013). In addition, only half of the batterers' treatment programs even addressed children's issues, including parenting issues or services to children, despite parenting of children being a main reeducation component in the Duluth model (Alderson et al., 2013). Most children receive services through child-welfare services because of reports of suspected abuse and neglect, rather than batterer-treatment programs (Alderson et al., 2013); Devaney, 2009). Although BIPs and child-welfare services focus on children's issues, the legal system must address children's needs in the context of DV.

In 2004, the National Council of Juvenile and Family Court Judges developed and distributed a guide to juvenile and family court judges to aid them in addressing child custody and visitation in DV cases (Zorza, 2009). The guide, revised in 2006, included language similar to that of federal DV legislation. In addition, the guide emphasized that DV could not be ignored when considering the best interest of the child. The guide

highlighted specific considerations in DV custody issues, including assuring safety of the victim and child, expedited processing of the case, and inclusion of professionals who have advanced training and knowledge of DV (Zorza, 2009). To address the safety of the children and victims, the use of visitation centers by the legal system and child-welfare programs have become the standardized approach (Brandt, 2007; Oehme & O'Rourke, 2012; Schulte, 2014; Stern & Oehme, 2005).

Visitation centers originated in the mid-1980s (Stern & Oehme, 2005) to provide children and parents a safe, neutral location in which to visit, while providing third-party observation or supervision when necessary (Brandt, 2007; Oehme & O'Rourke, 2012; Schulte, 2014; Stern & Oehme, 2005). Although Stern and Oehme (2005) identified the need for visitation-center personnel to be trained in DV, many centers use volunteers or interns. Brandt (2007) concurred with Stern and Oehme, adding that in some situations, family members are allowed to supervise. In addition, Schulte (2014) added that the judicial process of custody is anything but fair; rather, it is full of misunderstanding and myths.

Oehme and O'Rourke (2012) completed a study with 146 families that had participated in a visitation program, and found that nearly 75% of the children reported witnessing violence in the home. In addition, respondents indicated that over 70% of the families had experienced not only previous assaults, but also previous arrests and violations of orders of protection. Only 25% of the batterers had been court ordered to participate in a BIP (Oehme & O'Rourke, 2012). This statistic highlights the inconsistencies between the services offered and services actually used by families who

have or are experiencing DV. In addition, it highlights the lack of coordinated response that researchers in the field continue to recommend.

Male-Identity Development

An essential element of the understanding of the male batterers' experience, not clearly identified in the DV literature, appears to be the process of identity development. The Duluth model, an educational model, was never intended to replace a therapeutic intervention for male batterers; yet, that has occurred. This has led to a program that ignores a very basic component—identity—and the process of becoming men.

As previously discussed, exposure to DV has long-term detrimental effects on children, regardless of age or gender (Devaney, 2009; Katz et al., 2007; Levendosky et al., 2011; Margolin & Vickerman, 2011; Spilsbury et al., 2007). Although exposure to DV is detrimental at all ages, it appears that at certain stages of identity development, DV has even more detrimental effects. Adolescence is an especially critical time of identity development (Idemudia & Makhubela, 2011). Gender-identity development is at its height in male adolescents (Pleasants, 2007). Pressures to conform exist independently, as adolescents are as powerful as are the pressures to conform to a group (Moradi, Velez, & Parent, 2013). Erikson's (1959) psychosocial stages of development frame the identity development of male adolescents (as cited in Idemudia & Makhubela, 2011; Pleasants, 2007; Moradi et al., 2013). Although D. Phillips (2006) argued that the acceptance of Erikson's theory led to a reinforcement of violent men and a rigid patriarchal structure, Idemudia and Makhubela (2011), Pleasants (2007), and Moradi et al. (2013) indicated that Erikson's theory provides a lens through which to view the challenges that

adolescent males face. D. Phillips (2006) noted several new paradigms introduced in the 1990s, although the traditional masculinity paradigm has prevailed.

According to Pleasants (2007), the traditional masculine paradigm comprises aggression, dominance, competition, and strength. Traditional masculinity is disseminated not only by parents, family, and friends, but by the media and society (Idemudia & Makhubela, 2011; Moradi et al., 2013; Pleasants, 2007). Peralta and Tuttle (2013) identified traditional masculinity as "gender theory," and concurred with others about its predominance in the identity development of males. This pressure to conform cumulates at a pivotal point during adolescence, and typical responses such as confusion, fear, and anxiety are not compatible with the traditional male independent paradigm (Pleasants, 2007). Moradi et al. (2013) expanded on Pleasant's findings, indicating that a lack of a traditional masculine reference group only furthered a sense of confusion, fear, and anxiety among adolescent males. The process of identity development is clearly stressful on a normal adolescent male, and when combined with exposure to DV, the outcome may be a man who is unable to establish or maintain a healthy intimate relationship. When placed in the context of male batterers, these identity challenges highlight the issues that batterers' treatment programs currently do not address, and perhaps hinder the change that treatment seeks.

Trauma

The American Psychiatric Association (APA, 2013) recognized the outcomes of exposure to DV as meeting the criteria for trauma. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) provided definitions and identified that exposure to DV, even a single episode, as traumatic, possibly resulted in mental health

disorders or PTSD (APA, 2013). The trauma to children is considered pathological, since it is typically ongoing as children are unable to escape (Gelinas, 2001; Margolin & Vickerman, 2011). When violence is occurring, children are unable to escape it but simultaneously are developing emotionally and psychologically (Gelinas, 2001). Interpersonal trauma in children is pathological (Gelinas, 2001; Margolin & Vickerman, 2011); Gobin (2012) and Owen, Quirk, and Manthos (2012) indicated that Freyd (1994) posited a more accurate theory. According to Freyd, betrayal trauma theory asserts that trauma that results from a caregiver, such as a parent, requires the child to alter personal cognitions of the event to maintain the caregiving relationship. These cognitive adaptations or distortions may benefit the child; however, as the child matures and attempts to engage in more complex interpersonal relationships, the child becomes unable to identify unhealthy relationships and to respond to them appropriately (Gobin, 2012; Owen et al., 2012).

Pleasants (2007) argued against working with batterers through aggression methods or confrontation only reiterates the traditional masculine response. In addition, Peralta and Tuttle (2013) conducted a semi structured interview with 11 men currently participating in a BIP in which all batterers identified their inability to adhere to "traditional masculine roles," which they perceived as stressors that led to their acts of violence. D. Phillips (2006) suggested assisting clients to identify the norms and finding healthier alternatives to fit betrayal trauma theory. Although understanding of identity development and the effects of trauma on identity development have not been clearly demonstrated in the male batterers' treatment literature, literature on the role of the criminal-justice system in male batterers' treatment has produced solid results.

Criminal-Justice System

DV involves the criminal-justice system at many levels, from the initial responders to the violence, to the final decision when a batterer has successfully rehabilitated, and his contact with children has been determined. The criminal-justice system is a pivotal component of the entire response to DV. DV is the foremost call made to law enforcement (Sun, 2007). Nevertheless, police responses to DV have been criticized since the DV movement began in the 1970s due to the lack of offender accountability and victim blaming (Hirschel, Buzawa, Pattavina, & Faggiani, 2008; Shields, 2008; VanHasselt & Malcolm, 2005). Of the law enforcement agencies in northwest North Dakota, 81% have seen an increase in the number of DV calls in the 12 months, despite national trends indicating that the number of cases is dropping (Dooley & Ruzicka, 2013). Of calls made to law-enforcement agencies, 41% relate to DV (Nichols-Hadeed, Cerulli, Kaukeinen, Rhodes, & Campbell, 2012). Although some people believe DV is a private matter, the reality is that the criminal-justice system is intimately involved with this issue, as law-enforcement agencies are the first to be contacted.

Law Enforcement

The initial responses of law officers to DV calls in the early 1960s and 1970s generally involved a brief separation of the parties, marked by the idea that issues in the home should remain at home (Shields, 2008; Sun, 2007). The 1967 International Association of Police Officers manual directed law officers to intervene only as a “last resort” (White et al., 2005, p. 262). This mindset continued until the 1980s, when law-enforcement departments across the United States began receiving pressure from women’s right activists, civil lawsuits, and litigation, based on their poor response to

victims of DV (Hirschel et al., 2008; Shields, 2008; Sun, 2007; White et al., 2005). Following the pressures received at the state and national levels, law enforcement began installing a proarrest practice in responding to DV calls (Hirschel et al., 2008; Shields, 2008; Sun, 2007). Arrest rates following DV calls averaged around 10% prior to the 1980s, and increased to nearly 30% with the proarrest and mandated arrest changes (Hirschel et al., 2008). In 2000, over 577,000 incidents were reported to the National Incident-Based Reporting System to which all states submit their data; however, in 2000, only 19 states had submitted the data that Hirschel et al. used in their study. A great deal of freedom still exists in how law enforcement can respond (Sun, 2007). The increase in arrests has not been observed due to an increase in arrests of women or "dual arrests," rather than an increase in male arrests (Hirschel et al., 2008; Hovmand & Ford, 2009; White et al., 2005). Women now make up 20% of new arrests (Hovmand & Ford, 2009; White et al., 2005). Dual arrests have been allowed in many states under DV mandatory-arrest practices when a primary aggressor has not been identified, or in cases in which both parties suffered physical injuries (Hirschel et al., 2008). Shields (2008) added the specific training regarding DV that law officers underwent influenced law-enforcement responses.

Of law-enforcement agencies in northwest North Dakota, 90% required law officers to receive specific DV training; however, less than 40% of Sheriff's deputies and 54% of dispatchers actually received the training (Dooley & Ruzicka, 2013). This is disconcerting, considering that dispatchers are the first responders who take the first call for help, and that Sheriff's deputies are responsible for responses to DV calls. In addition, topics of on-scene investigations, primary-aggressor issues, and awareness of community

resources were marked as major areas in need of ongoing training (Dooley & Ruzicka, 2013). These issues once again indicate the lack of coordinated community responses that are needed in DV, and that are actually considered essential elements of the Duluth model.

Law officers used two approaches: supportive and control. Supportive approaches include compassion, understanding, education, and referral to services; control approaches include arrest, personal searches, and demanding compliance (Sun, 2007). Although Sun (2007) labeled and categorized specific approaches, several other researchers identified responses by law officers as critical to the steps victims will take. A combination of approaches demonstrated the most significant effect (Hovmand & Ford, 2009; White et al., 2005). A coordinated community response in which trained police officers deal with the arrest, while social workers or other trained mental health professionals respond and directly address the victim, have been found to be one of the most effective approaches, and have shown to increase the likelihood of service to both victim and batterer (Hovmand & Ford, 2009; White et al., 2005). Weisz, Black, and Nahan (2005) disagreed that a coordinated community response improved outcomes; rather, they indicated that listening to the victims and batterers was far more important. Sun found that law officers who were untrained in DV referred more victims to marital therapy than to DV shelters or programming. In contrast, Sun and Dooley and Ruzicka (2013) found that over 90% of law officers stated that they first referred victims to shelters. Interestingly, they did not mention referring the batterers to services, programming, or treatment (Dooley & Ruzicka, 2013).

Sun (2007) completed a systematic system observation of officers in a large metropolitan community at two separate law-office agencies. Sun found that female officers offered more supportive services to victims, yet both male and female officers offered the lowest service to victims in DV emergency shelter services. This finding contrasts with what is considered an essential component of the Duluth model: safety of the victim. An additional finding emerged from a study of 710 law officers in Florida indicating that 33% of law officers knew of officers who had committed unreported acts of DV, and over 11% had reported being violent with an intimate partner (Valentine, Oehme, & Martin, 2012). A comprehensive and coordinated response is essential to meet the needs of victims and batterers (Dooley & Ruzicka, 2013; Hovmand & Ford, 2009; Valentine et al., 2012; Weisz et al., 2005; White et al., 2005). Although first responders, that is, law-enforcement agencies, were the initial step in the prosecution process, judges were equally critical (Weisz et al., 2005).

Court System

Although this study was not intended to cover the historic evolution of the court system, it is important to place the current study in the framework of how DV was viewed in the court system and how it was addressed. The federal government has historically viewed the home as its own form of government where husbands were given the "authority to rule" (L. J. Harris, 2010, p. 529). This contradiction between home and "public" occurred also at an international level (Hasselbacher, 2010). The division between private and public was further solidified by the idea that men were the ones to decide what was deemed appropriate behavior for both sexes (Hasselbacher, 2010). This framework coincides with the direction taken by law-enforcement agencies that

responded to domestic calls only as a last resort. L. J. Harris (2010) indicated that the change in the court system began in the context of divorces, which were granted due to violence; many others argued that the change has not even begun.

Only 54% of DV victims who reported the initial incident to law enforcement were even willing to speak to the prosecutor, and less than 10% of the cases led to an arrest (Weisz et al., 2005). In addition, of those 10%, only 4% included a felony arrest. The hope that prosecution is going to hold batterers accountable is possible, but is not the totality of the situation (Dempsey, 2007; S. Edwards, 2012). Prosecutors have been found, many times, to not even prosecute if the victim is not willing to testify, despite the presence of physical evidence (Edwards, 2012). Prosecution of DV cases has followed the traditional practice of not getting involved in "private matters" (Edwards, 2012; Lippman, 2013). Prosecutors indicated that prosecution of batterers was considered low prestige and conviction rates were quite low, reinforcing the desire not to prosecute (Lippman, 2013). In addition to the lack of involvement, another challenge is that the court may be involved at a civil level, which further leads to the ambiguity in decision making.

Aside from custody matters, victims of DV are most likely to use the Protection Order (PO) in civil or family court (Nichols-Hadeed et al., 2012). PO is available in all 50 states, and regardless of where they are granted, they are enforceable in all jurisdictions of the United States. The PO is issued in a civil or family court setting, and can be completed in conjunction with a criminal case or divorce or child-custody matter, or it can be sought independent of these actions (Nichols-Hadeed et al., 2012). The PO does not enter the criminal court unless it is violated. Family and civil courts hold the

ideological values of procedural fairness, whereas DV advocates continue to identify the patriarchy as the issue that needs to be addressed (Lippman, 2013; Salem & Dunford-Jackson, 2008). These vastly held differences collide in the context of court hearings and findings (Salem & Dunford-Jackson, 2008). The challenge is that this court system is held accountable for imposing consequences on the batterer. Most victims found the court process intimidating, confusing, and dangerous; and longer court processes increase the likelihood the victim will become uncooperative or give up (Weisz et al., 2005). Lippman (2013) identified another significant challenge across the US related to a lack of not only legal services, but also a true understanding of the complexity of DV.

The standard in family court is to make every attempt to sustain co-parenting of children (Jaffe, Crooks, & Bala, 2009); and despite concerns about children's and victims' safety in DV cases, those concerns are rarely addressed. Rivera, Zeoli, and Sullivan (2012) completed a study with women who had divorced their abusive husbands, and found that despite the findings of DV, judges ordered mediation with meditators who had no training in DV. Most women reported they not only informed the mediator of the abuse, they also informed them of the concerns for the children (Rivera et al., 2012). A more coordinated comprehensive approach is needed to provide the best situation for victims, batterers, and children.

To effectively address the complexity, legal personnel must complete a thorough assessment that considers not only the concerns of the victims and children, but also the needs of all of the parties (Jaffe et al., 2009; Lippman, 2013; Salem & Dunford-Jackson, 2008). A hierarchy of conflicts ranges from normal conflict involved in child-custody disputes to dangerous conflict that is seen in DV (Jaffe et al., 2009). For collaboration to

work, the court system, the professionals who have the knowledge of DV, must begin by commonly defining what goals the group is working toward: healthy families (Salem & Dunford-Jackson, 2008). In addition, the group must clearly listen to each other throughout the process (Salem & Dunford-Jackson, 2008). Jaffe et al. added not only listening, but also responding comprehensively to the needs of the family is essential, including BIP, victim and children's services, supervised visitation centers, and court monitoring.

One state has attempted to create a coordinated criminal-justice system to respond to DV. The State of New York developed a specialized DV court in 1996. In 2000, it expanded and added Integrated Domestic Violence (IDV) courts (Lippman, 2013). The IDV court combines the civil, criminal, and family courts into one system in which one judge hears and addresses all areas. This structure led to a more seamless process for the entire family, a large reduction in actual hearings because several matters are addressed at the same time, and increased safety and accountability (Lippman, 2013). In 2011, more than 3,000 families were served in IDV, and DV courts heard nearly 33,000 new cases. Significant work went into finding the judges who were not only willing, but also dedicated to receiving extensive training on DV, and to working closely with the service providers to the victims, children, and batterers. The state of New York could potentially save nearly $85 million (Lippman, 2013).

Summary

The literature clearly suggested that DV is the leading public health concern facing women across the globe and is now considered a global human rights issue (Abramsky et al., 2011; Clements & Holtzworth-Munroe, 2008; Gover et al., 2011;

Hayward, Steiner, & Sproule, 2007; Smith, 2011; Tollefson et al., 2009). The costs are expansive not only for the family experiencing DV, but also for society. Although healthcare, court, and housing costs are massive, so are the public costs (Brown, 2008; Chrisler & Ferguson, 2006), which are largely ignored.

The United States operates the largest and most expensive prison system (Kenemore & Roldan, 2006). General recidivism rates have remained between 40 and 60% over the past 30 years for all criminal offenses (Hughes & Wilson, 2002) whereas approximately 20 to 40% of male batterers reoffend annually (Tollefson & Gross, 2006). Not only do batterers reoffend, the services they have been offered continue to demonstrate lack of efficacy.

The review of literature indicated that although the treatment provided to male batterers developed reactively, the treatment that has become the standardized model has never included the batterer's perspective. The voice of the male batterer has virtually been silenced. The Duluth model was developed in the 1980s by a group of women advocates and quickly became a national model for male batterers' treatment; yet the literature has clearly indicated that this model is unlikely to be monitored or closely followed by facilitators. An additional issue is facilitators' education, ranging from none to advanced training in DV. Regardless of what type of treatment is currently being provided, the data strongly indicated it is ineffective. Recidivism rates following batterers' treatment ranged from 15 to over 65% (Jewell & Wormith, 2010; Olver et al., 2011; Rosenberg, 2003; Tollefson & Gross, 2006; Waldo et al., 2007). The problem is complex; but one element continues to be lacking in the literature, what batterers believe they need in treatment.

The lack of treatment efficacy in male batterers' treatment is well founded, evidenced by the high recidivism rates regardless of treatment modality. These rates are coupled with the societal concern of the reentry of batterers into society (Arias et al., 2013; L. A. Phillips 2010). Allowing batterers to have their voices heard regarding treatment development and methods is an essential first step in improving batterers' treatment.

The next chapter describes the qualitative phenomenological study. In the chapter, I identify participants, interview questions, and data collection. Further, I include the study organization and method of analysis.

Chapter 3: Research Method

Introduction

Although significant research exists on victims of DV, the research about providing services to perpetrators of DV is lacking. Although the literature highlights the high rate of recidivism among batterers, the literature is much less definitive on the actual theoretical and conceptual frameworks that have guided treatment modalities for batterers (Aymer, 2008; Corvo et al., 2008; Day et al., 2009; Mankowski et al., 2002; Moore, 2011; Polaschek & Collie, 2004). In addition, treatment offered and implemented remains inconsistent (Dalton, 2009; Dutton & Corvo, 2007; Mankowski et al., 2002; Saunders, 2008). The lack of any national oversight of batterers' treatment programs continues to contribute to the current challenge of identifying effective treatment modalities (Stover & Lent, 2014). Although I found that the current treatment being offered, regardless of modality, has proven ineffective, questions regarding what batterers believe they need remains unanswered. To narrow this gap, the focus of this qualitative study was to gather experiential knowledge from batterers themselves regarding what they, as experts in the field, believed needs to be included in treatment. The focus of this chapter is on the research design and rationale, the role of the researcher, methodology, participant-selection logic, population identification and sampling strategies, sample size, instrumentation, and sources of data. Furthermore, I also present procedures for the main study.

Research Design and Rationale

Qualitative methodology allows the voice of individuals who have experienced a specific phenomenon to be heard (Creswell, 2013). Phenomena of interest to social

scientists cannot always be studied in a traditional quantitative sense (Frankfort-Nachmias & Nachmias, 2008). To truly understand what batterers believe they need in treatment, the information must come directly from the batterers. Maxwell (2013) stated that the specific qualitative methodology selected derives not only from the literature, but also from the research questions, and is flexible and responsive to study participants. Although multiple qualitative methodologies exist, I selected phenomenology for this study. I present a brief historical overview of phenomenology as well as the specific phenomenological approach selected.

Formulated by Husserl in the early 20th century, phenomenology is an alternative to traditional methods of acquiring knowledge about the world (Giorgi, 2008, 2012; Sousa, 2005). Husserl's approach focused on gaining understanding of the lived experiences of others through language (Finlay, 2009; Giorgi, 2012; McConnell-Henry, Chapman, & Francis, 2009; Sloan & Bowe, 2014; Sousa, 2005). Husserl's phenomenological approach included a specific attitude of the researcher that prevents any interpretation of the data; rather the focus is on describing, as succinctly as possible, the phenomenon (Giorgi, 2012; Sloan & Bowe, 2014). Husserl's approach, the original form of phenomenology, eventually became known as transcendental or descriptive phenomenology. Although Husserl's approach was expanding, a student, Heidegger, began to develop another approach to phenomenology (Finlay, 2009; Giorgi, 2008; McConnell-Henry et al., 2009; Sloan & Bowe, 2014).

Heidegger believed that Husserl's element of removing oneself or bracketing from the data was impossible; thus the new approach moved from describing a phenomenon to interpreting the phenomenon (Finlay, 2009; Giorgi, 2008; McConnell-

Henry et al., 2009; Sloane & Bowe, 2014). Heidegger's phenomenological approach became known as interpretive or hermeneutic phenomenology (Finlay, 2009; McConnell-Henry et al., 2009; Sloane & Bowe, 2014). Hermeneutic phenomenology considers the researcher an active participant in the process of meaning making and thus meanings are never fixed but rather are emergent and contextual (Finlay, 2009; McConnell-Henry et al., 2009; Sloane & Bowe, 2014). I chose the hermeneutic approach of phenomenology for this study.

I chose the research question to allow study participants to describe their own experiences, yielding a deep understanding of the phenomenon to emerge (Creswell, 2013). In addition, I chose and presented questions in a fashion to not only allow batterers to voice their opinions, but to do so without having to identify themselves as batterers; rather, they were treated as the experts or holders of the knowledge I was seeking. I initially left the question broad and open-ended to allow for the essence of the descriptions to emerge (Creswell, 2013). The research question for the qualitative, phenomenological study was: What do you believe is the experience of a male batterer participating in a standardized male batterers' treatment program, based on the Duluth model?

I developed the research question to allow batterers to provide answers without identifying themselves as batterers. This is important as it allowed for not only confidentiality of study participants, but encouraged study participants to provide genuine answers without negative consequences to their own treatment. Janesick (2011) and Maxwell (2013) identified that the research questions used by a researcher should be flexible to meet the needs of participant and researcher. In addition, the hermeneutic

approach allows for the incorporation of perceptions of both the participant and researcher (Finlay, 2009; Sloan & Bowe, 2014). The research question allowed themes to emerge regarding batterers' treatment from the perspective of batterers themselves. In addition, Janesick emphasized that the researcher incorporates not only the spoken, but the unspoken word of participants. According to Sloan and Bowe (2014) hermeneutic phenomenology seeks spoken and unspoken language to arrive at a full understanding of the experience.

Although I chose the hermeneutic phenomenological approach, I considered other qualitative methodologies. Grounded theory may have provided an equally appropriate study for this phenomenon, as it would have allowed a theory to emerge from the data; however, the information sought from the participants was to understand the essence of their experience (Creswell, 2013). According to Creswell (2013), grounded theory is appropriate to understand activities or events; and although grounded theory appeared to be too broad, the narrative approach appeared too narrow to answer the research questions developed. The narrative approach would have focused on one rich story from a single batterer, but this would not have answered the questions related to my study.

I considered case study, but deemed it problematic to obtain multiple sources of information from participants, and the research question sought the lived experience of the phenomenon (Creswell, 2013). As previously reported, I did not consider ethnography, as the research question sought information unrelated to a cultural sharing group, nor did they require immersion in their lives. Qualitative research provides several approaches to address a study, and although many of them could have been employed in this study, I identified the hermeneutic phenomenological approach as the most

appropriate. Future study may allow a grounded-theory approach to be used, and could allow for additional knowledge to be added to the field.

Role of the Researcher

According to Creswell (2013) and Maxwell (2013), the role of a researcher should be clearly outlined to provide transparency for the study, but also to understand how the researcher impacted the study. Creswell and Maxwell indicated that qualitative researchers should identify their personal and professional views, assumptions about the research process, and their role as a participant. Just as study participants have a history that impacts their stories, so does the researcher. According to hermeneutic phenomenology, as the researcher, I bring my own history and perceptions to the current experience (Finlay, 2009; Giorgi, 2008; McConnell-Henry et al., 2009; Sloan & Bowe, 2014). To position myself appropriately in the story, I will share my views on DV, battering, and batterers' treatment.

I am a White, middle-aged woman who has worked in the DV field for the past 18 years in a variety of positions. I am a licensed, independent, clinical social worker who has worked as a director of a DV program, case manager for child-welfare programs, therapist for victims and children of DV, and speaker on the issue of DV. In addition, I have participated in and provided training for law-enforcement officers, addiction-treatment-center personnel, community members, and students on issues related to DV. I have also volunteered for DV programs and am currently a board member of a local DV program. These experiences have provided opportunities for me to understand the phenomenon of DV from multiple perspectives. In addition to my personal experiences, I have also obtained knowledge through my education and professional training. I currently

hold a Licensed Independent Clinical Social Work license in my state, which required 3,000 postmaster's graduate clinical training hours under a licensed psychiatrist, which allowed for advanced training in treating those with a myriad of complex mental health diagnoses.

Despite the knowledge and experience I have gained, I had to be open to interacting with participants and immersing myself in the complex context of DV. It was imperative that I did this to truly hear what the participants were saying and understand the phenomenon from their perspective. The hermeneutic phenomenological approach allowed for my own experiences and perceptions to be included. Maxwell (2013) reiterated the hermeneutic approach, indicating that these experiences should be included through transparency. Maxwell added to Janesick's (2011) thoughts indicating that being a solid researcher requires not only constant awareness, but practice of skills. In anticipation of the proposed study taking place, I observed the batterers' treatment group as a community member at large, as well as removed myself from any board-member work that entailed direct work with victims. It is important to point out that a majority of my work has been done directly with victims, and aside from providing training to batterers in the context of their group participation, I typically have advocated for and represented victims. Although I have taken these steps to focus solely on the study, it is more important that I, as the researcher, take the appropriate and necessary steps to complete an ethically sound study. I believe this is where my current license, education, and professional experience will aid me.

I refrained from causing any harm or distress to any and all potential study participants by allowing for voluntary participation or withdrawal from the study at any

time, without consequence. In addition, the questions I asked of participants allowed them to answer the questions without giving any identifying information about themselves. According to Creswell (2013), researchers must always respect oppressed and disempowered populations, develop rapport and trust, and create transparency to assure that participants are never harmed.

Janesick (2011) found that the unspoken word of participants is just as important as the spoken word, reiterating hermeneutic phenomenology. To allow for a full and comprehensive story to emerge from participants, I incorporated not only the physical description of the environment, but also the nonverbal responses of participants in my written transcripts. Janesick indicated that this information not only allows for the full story to emerge, but also allows for the transparency that is essential in a sound and ethical study. In addition, I provided individual, family, and group therapy for nearly 10 years, which has refined my interview and assessment skills. My professional experience has allowed for a deep empathy and compassion to develop for individuals and groups with which I engage.

My data-analysis tasks identified commonalities and differences in participants' responses to the questions. In addition, I noted and reported the nonverbal responses to offer a more holistic picture of the lived experiences of participants. According to Sloan and Bowe (2014), I must not only express my thoughts but use them in analysis of the data provided by participants. This reflexivity allowed for interpretation of the phenomenon to emerge. Therefore, this study offers a participants' view of the current Duluth-model treatment modality and what participants believed needs to be incorporated to improve the approach.

In ethical data-collection, Creswell (2013), Janesick (2011), and Maxwell (2013) specified the safety, security, and protection of the participants must be of utmost importance. To this end, I took several steps. I identified study participants from a current treatment group; thus I conducted no additional recruiting and offered no incentives for participation in the study. I assigned pseudonyms to participants who agreed to be involved in the study (Creswell, 2013). In addition, I treated all material collected as confidential throughout the study. Finally, Creswell identified the need to respect the research site, which was the group's meeting site, LSSND.

I asked participants to commit to two interviews. The first interview focused on obtaining answers to the prepared interview questions, whereas the second interview focused on completing a member check with the participants. The second interview allowed participants to review the text transcript to assure accuracy of their reports.

Methodology

In the qualitative paradigm, context is an essential element (Janesick, 2011). I describe the site of the current study for the context to be understood. The State of North Dakota is considered rural in nature, with 9.5 persons per square mile (Moos, 2009). White is the major ethnicity, with Native American being the largest minority (5.6%) (Moos, 2009). However, a large influx of individuals have come to the western part of North Dakota due to oil-exploration activity. This is important to note because the study was completed in this area of oil activity. In the area of interest, 65% of households are considered to be family households, with 54% being married-couple families (Moos, 2009). According to Stenehjem (2011) total crime increased by 10.9% in North Dakota in 2011, with violent crime, including aggravated assault and rape, increasing by 16.1%.

From 2010 to 2011, aggravated assault cases increased 22.8% (Stenehjem, 2011). Six of the 14 deaths in 2011 were the result of DV in North Dakota (Stenehjem, 2011).

The research site, LSSND, is a regional service center that provides services to a seven-county region in north central North Dakota. . In 2011, this seven-county region reported 160 aggravated assault charges (Stenehjem, 2011). This is important to note as most referrals to the male batterers group resulted from these charges. Also, two of the seven counties reported no assaults, and one police department made no report. I selected this site because North Dakota state has historically been predominantly White, and with the current oil-exploration activity, the demographics in the region have become much more diverse, which aided in my research findings. In addition, LSSND provides the standardized Duluth model to the entire region using a licensed professional, adding to the authenticity of the program and complies with the North Dakota Adult Batterer Treatment Standards (North Dakota Adult Batterers Treatment Standards Forum, 2011).

Study Participants

I contacted the research site and introduced the study through the main facilitator of the male batterers' treatment group as well as the facilitator's immediate supervisor, the program director. I prepared and had the facilitator distribute a letter outlining the research study (see Appendix B). I then followed up a week later by answering any questions from potential participants regarding the study. The only requirement for participation in the study was that the individual had to be a current treatment member. I read the consent form to the participants were read the consent form, asked them to read it themselves, and then sign the form (see Appendix C). I gave a copy of the consent form to participants.

Study participants differed in ethnicity, age, education level, occupation, marital status, income level, city of origin, weeks in treatment, and personal history. These individual differences allowed for exploration of treatment experiences across a diverse sample (Creswell, 2013; Maxwell, 2013). The protection of vulnerable populations, particularly those under 18 or those with cognitive disabilities, was already addressed by the treatment guidelines.

Sampling Procedures

I planned to select 10 participants, as researchers have used this sampling size for phenomenological studies (Mason, 2010). Although I chose 10, my goal was that all of the individuals would be willing to participate, which would double this number; however, this did not occur. According to Mason (2010), the number of participants selected should be based on saturation, not convenience for the researcher. Despite recognizing this variable, I was unable to publicly advertise for batterers for this study; therefore, I sought saturation from the information provided by treatment participants. Advertising would have lessened the authenticity of the research, as it could have allowed those who had not been found guilty of DV to potentially join the study.

I used purposive sampling to gather information-rich representatives who were in various stages of the treatment within the study parameters (Creswell, 2013; Maxwell, 2013). I selected individuals who were willing and able to participate in the study and articulate their experiences with the treatment modality. In addition, selected participants needed to remain in treatment over the two interviews to allow for consistent and timely data gathering.

To gain access to potential study participants, as mentioned, I contacted the main facilitator of the treatment group as well as the program director. I completed a letter of cooperation (see Appendix D) with LSSND, specifically with the main facilitator and the program director, who did not receive any compensation or undue influence to recruit or encourage participation in the study. I requested and received a formal letter of cooperation, adhering to the Walden University Institutional Research Board (IRB) guidelines, from LSSND following committee approval of the proposal.

Instrumentation

I served as one of the most basic instruments as the main researcher who interviewed all of the participants (Creswell, 2013; Janesick, 2011; Maxwell, 2013). For this study, I used three other instruments: the demographic data sheet (see Appendix A), the interview guide (see Appendix E), and the study debriefing form (see Appendix F).

Demographic data sheet. I developed the demographic data sheet (see Appendix A) based on the research purpose of developing additional themes relevant to the study. The demographic sheet gathered information such as age, ethnicity, marital status, education level, occupation, income level, and weeks in treatment. I collected the demographic data by having participants read and write their responses on the form. This eliminated any pressure from the participants and allowed them as much time as needed to read and respond. I chose to have participants complete this data sheet at the end of their first interview. According to Creswell (2013), answering these questions at the end of the interview decreases suspicion of participants.

Interview guide. I created the interview guide based on the research question, research purpose, and the literature review. The interview guide increased the validity of

the study as it engaged all participants in the same topic (Creswell, 2013; Janesick, 2011). According to Janesick (2011), the use of an interview guide assures consistency for the study and the researcher, thereby allowing for the collection of sufficient data.

I collected the data from the interview guide in a face-to-face interview. I informed all participants to allow for at least 2 hours for the initial interview, to provide them with sufficient time to answer each question in detail without interruption. This time also allowed for consent and debriefing. I took field notes during the interview and audio-recorded the sessions.

Audio taping of interviews. I attempted fidelity in the interviews through the use of audio taping (Creswell, 2013; Janesick, 2011). I also took handwritten notes during the interviews that included subjective and objective data (Creswell, 2013; Janesick, 2011). I began the audio recording following the signature of the consent form and stopped the recording after the debriefing. I then transcribed each audio recording within 3 days of the interview to allow for repetition of the data (Janesick, 2011). This immersion allowed for a thorough analysis of the data. I transcribed the audio recordings using a Microsoft Word format and then used the same method with the participants for member checking (Creswell, 2013). The exit from the study occurred after reviewing the final transcripts and summaries with the participants.

Study-debriefing form. I based the study debriefing form (see Appendix F) on the research process, and used it as the last step of the interview, and as an exit from the first and second interviews. The post interview debriefing involved me interviewing the participants at the end of the interview in an attempt to explain the goals, purposes, and outcomes of the study, and to answer any questions or concerns from the participants.

During this step, I asked participants to read, sign, and date the debriefing statement. I also signed the debriefing statement at the same time, and gave a copy of the signed form to the participant. The debriefing document contained the research site's 24-hour crisis hotline telephone number. The document also included a reminder that any cost in seeking mental health or medical assistance was at the participant's own expense (see Appendix F).

To review, I collected the majority of data for the study debriefing form from participants following the end of the first interview. I collected the data by reviewing the debriefing form and collecting the participant's signature. I also signed and discussed the tentative date and time for a brief second interview, which occurred about 3–4 weeks after the first interview. I provided another copy of the debriefing form to participants, following completion of the second interview. I used the study debriefing form for all participants across the Phase I and Phase II data-collection periods.

With respect to the four data-collection instruments, I addressed concerns about their validity and truthfulness for their use in the qualitative study. To address these concerns, I asked dissertation committee members to review the instrument; committee member have experience with qualitative research and methodology and experience in the field of DV. The committee reviewed the instruments and evaluated their validity and reliability as subject-matter experts related to the research purpose and questions (Creswell, 2013; Janesick, 2011).

Procedures for the Pilot Study and Main Study

This section describes considerations of the design. Qualitative studies unfold, emerge, and develop through the data provided by participants, thus the researcher must

remain open to this flexibility (Creswell, 2013; Janesick, 2011). The first two interviews in Phase I served as a pilot study to better understand recruitment, field notes, and data-collection instruments for the main study. Preliminary findings from the first two interviews provided insight to identify findings and summarize in written form. The first two participants also provided data for the member-check process (Creswell, 2013). The intended purpose of the pilot study was to inform me of any changes that needed to be made to improve instrumentation or data-analysis strategies. In addition, I would have informed the Walden University IRB if any changes were needed following the pilot study.

Prior to beginning data collection, I completed the Walden University IRB application and received approval to conduct the study. At the time of this study, I was also employed as an Instructor at Minot State University, which required that I obtain IRB approval from the Minot State University office of research.

Procedures for Recruitment, Participation, and Data Collection

Following are the steps that I took for study recruitment and participation for the pilot study and main study. The following 10 steps describe the process I completed.

Step 1: How existing data or contact information of potential participants were obtained. I selected the agency that served as the research site based on convenience sampling. I contacted the agency's group facilitator and program director regarding accessing the male batterers' treatment to recruit research participants. After obtaining approval from both IRBs, I attended a session of the male batterers' treatment where I invited all group members to participate in the study. In addition, I gave a letter

of invitation (see Appendix B) to each participant who wished to take one, and left several letters with the group facilitator.

Step 2: Initial contact with potential participants. Initial contact with potential participants began in Step 1 in a group setting where the study was described, but continued individually with potential participants who expressed interest. I discussed the purpose of the study individually with potential participants and answered any questions.

Step 3: Informed-consent procedures. I conducted the interviews 1 to 2 weeks following initial contact with the participant, depending on availability. Due to participants attending the batterers' treatment group weekly, I completed the interviews with the participants before the group sessions to limit disruption to participants' schedules. At the time of the interview, I spent a few minutes engaging the participant in conversation. I then used the consent form (see Appendix C) as a guide for the verbal explanation of the study. The informed-consent process allowed me to explain the study, answer participants' questions, and for the participant to consider all options.

The only individuals allowed during the interview were the participant, one of the group facilitators if the participant wished, and me. I then reminded the participant that his name would be protected through a fictitious name and identification code (see Appendix G). The code sheet that contains the protected names is kept in a locked cabinet that is only accessible to me (see Appendix G).

The participant's signature on the informed-consent form provided written documentation of the participant's agreement to participate in the study. I signed the consent form at the same time as the participant, and gave a copy of the signed consent form to the participant. At the same time, I ascribed a fictitious name and identification

code to the participant, which I used throughout the study to protect the participant's identity and confidentiality.

Step 4: Pilot activities. I used the first two interviews of Phase I as a pilot to test run the data-collection tools and process. The data-collection tools included the consent form (Appendix C), demographic data sheet (Appendix A), interview guide (Appendix E), and debriefing form (Appendix F). If any modifications were needed, the Walden University IRB and Minot State University Office of Research would have been informed.

Step 5: Data collection (interviews). I conducted the individual interviews at the research site in a private office during this step. I began the interview with a brief explanation of the nature of the study. The interviews involved questions that could answer the question of the study. I audio recorded the interviews, and took field notes on the interview guides that contained the fictitious name and identification code.

Step 6: Data collection (demographic data sheet). During this step, I asked the participant to complete the demographic data sheet (see Appendix A). This step was completed following the interviews, and asked the participants basic demographic information including marital status, education level, age, race, and number of children.

Step 7: Interview debriefing (debriefing form). I asked participants to read, sign, and date the debriefing form (see Appendix F). I also signed the form and gave a copy to the participant. The debriefing form had a 24-hour emergency mental health phone number, as well as a reminder that any mental health or medical care sought would be at the participant's expense.

In addition to signing the form, I asked the participant if he would be willing to meet with me for a second interview. The second interview was scheduled approximately 3 to 4 weeks on the same days as the group to facilitate the process. The second interview was scheduled for 30 to 45 minutes.

Step 8: Data analysis. For this step, I describe the data analysis in a separate section of this document. Table 1 illustrates the data that the research question was intended to provide as well as the tools that were used to collect and analyze the data.

Table 1

Linking Research Question to Data Collection, Data Points, Source, and Data Analysis

Data-collection tools	Data points yielded	Data source	Data analysis
Demographic data sheet	Demographic data sheet Identifies participant characteristics (Questions 1–6)	Demographic data sheet Participant	Demographic data sheet Qualitative analysis of responses identifying themes, patterns, and meanings to include with other data
Interview questions	Interview questions Identifies participants descriptions of male batterers' treatment (Questions 1–4)	Interview questions Verbatim transcripts from participants and researcher audio-taped interviews	Interview questions Creswell (2009) and Miles & Huberman's (1994) method of analysis using descriptive codes and integrating across multiple sources
Debriefing form	Debriefing form Identifies participant information to arrange second, follow-up interview (Questions 1–2)	Debriefing form Participant provides to the researcher	Debriefing form Qualitative analysis of response to identify themes, patterns, and meanings included with other data

Step 9: Follow-up meeting with participants to review transcripts and perform member check. I used the second interview to gather feedback from the participants and validate my findings through the process of gaining participants'

validation. This was done by reading the transcript and confirming the text reflected in the audio taped discussion, discussion of salient responses, and showing participants partial trends to check participants' opinions. The member-check discussion was not audio taped. By completing the member check step, the participant had the opportunity to suggest changes, if necessary.

Step 10: Dissemination of the results of the study. I asked participants on the Study Debriefing Form (see Appendix F) if they wished to be informed of the study results and in what form (e-mail or mail), and this response dictated if and how the information would be shared with the participants. I provided the agency a written summary following completion of the study. I shared the written summary verbally with the agency at a follow-up meeting.

Data Analysis and Interpretation

According to Miles and Huberman (1994), data analysis and interpretation are completed with words in qualitative research. Although Miles and Huberman identified qualitative data as words, Creswell (2013) and Frankfort-Nachmias and Nachmias (2008) indicated that it is the meaning that the words develop to form the description that is essential in qualitative analysis. In addition, hermeneutic phenomenology focuses on the meaning making ascribed by the participant and the researcher (Finlay, 2009; Sloan & Bowe, 2014). I combined the words provided by participants with my thoughts to form the data used for data analysis and interpretation. I followed hermeneutic phenomenological methods and Creswell's recommendations of coding individual meanings of the phenomenon, as well as meaningful themes from the group, to arrive at a

final interpretation or conclusion. Following is a brief step-by-step overview of the data-analysis process.

Step 1: Research field notes and journal. I used a journal to not only record the running narrative experience, but also my reflections and thoughts throughout the study. Janesick (2011) highlighted that journal writing has been a long and reliable research tool used in arts and humanities. Furthermore, Janesick identified the journal as enhancing the researcher, the main research instrument. The journal enabled me to constantly evaluate and interpret not only the data, but my thoughts related to the data following hermeneutic phenomenology.

Step 2: Interviews (see Appendix E) and field notes. I transcribed the interviews, which allowed me to document additional field notes. After the transcription, I read through and recorded all significant and relevant statements through coding. I began with descriptive codes that were further refined into inferential codes (Creswell, 2013; Miles & Huberman, 1994). These codes allowed for meaning units to emerge for further analysis. According to Sloan and Bowe (2014), the ongoing dialogue with the data allows for a summarization of the experience to develop. The next step included providing verbatim examples of the meaning units or themes that emerged from the participants.

Step 3: Integration. From the individual and researcher's notes, I created a composite description of the experiences of male batterers participating in male batterers' treatment. In this step, I integrated all descriptions into one universal description.

Data-Integration Process Across Multiple Methods and Sources

The information I collect through the Demographic Data Sheet (see Appendix A) resulted in finding themes, patterns, categories, and meanings to include with other information. I used the final demographic data sheets to identify common themes and note inconsistencies and differences. In addition, the information I collected on the Study Debriefing Form (see Appendix F) resulted in describing participants' thoughts or comments about the first interview, if any. Finally, the verbatim transcripts from the audio recorded interviews captured participants' descriptions about the male batterers' treatment group.

Discrepant Cases, Negative Cases, or Disconfirming Evidence

After determining themes, I searched for data that disproved the themes or did not fit into the categories that formed (Creswell, 2013). If the data did not fit, I suggested modifications.

Issues of Trustworthiness

Validity, reliability, and confirmability are the tools I used in this research to establish trustworthiness (Creswell, 2013; Miles & Huberman, 1994). I describe these concepts next.

Validity

To assure validity in the trustworthiness framework, I used multiple data sources including the written demographic data sheet, participants' spoken words, my observations, and field notes. I implemented the strategy of triangulation with the multiple sources (Creswell, 2013). In addition, I used the study debriefing form to

member check for accuracy. Finally, I clearly reported the bias I brought to the study to present an open and honest study (Creswell, 2013).

Reliability

According to Creswell (2013) and Miles and Huberman (1994), the core issues of reliability are consistency and continuity of the process and the researcher. To achieve reliability, I clearly described the steps I executed in acquiring data while also documenting my steps as the researcher in the field journal. In addition, I checked the transcripts for obvious mistakes that participants and I might have made. Finally, I clearly outlined all steps in the data analysis and interpretation leading to solid documentation (Miles & Huberman, 1994).

Confirmability

According to Miles and Huberman (1994), confirmability is also known as external reliability. The emphasis is on the neutrality of the study, achieved through an open and honest account of the researcher's bias, as well as creating a clear paper trail of the actions taken by the researcher (Miles & Huberman, 1994). I achieved confirmability through the use of my field journal, which allowed me to provide an open, ongoing, honest account of the research process, as well as the rationale for the decisions I made. I also used the field journal to document my personal thoughts and biases throughout the study process.

Ethical Procedures

Ethical considerations for this study included access to and recruiting the participants, data collection, data procedures and treatment, and protections of the confidential data. The next section addresses these ethical considerations.

Access to the participants. Prior to conducting the study, I completed the Walden University IRB form and Minot State University IRB form. I received approval from the corresponding entities prior to beginning. Following the completion of the IRB permissions, I obtained approval through a letter of cooperation (see Appendix D) with LSSND.

Recruitment. I recruited men who are currently participating in the male batterers' treatment group. I explained the purpose of the study to all potential participants in a group setting, as well as in an invitation letter (see Appendix B) that outlined the study, including the freedom to refuse or withdraw participation at any time without penalty. The rights of the participant were further outlined in the consent form (see Appendix C).

Data-collection activities. The participants completed the consent form (see Appendix C), which outlined the participant's right to withdraw or refuse to participate in the study at any time without penalty. In addition, the consent form reviewed the data-collection process for the participants. To protect the confidentiality of participants, I assigned each participant an identification number. The research site may request the use of their agency identity or real name in dissemination of study findings in the future. Prior to disseminating the findings, I would request written approval to disclose the agency name.

Treatment of data. All information provided by the participants will be kept confidential except when the law required confidentiality to be breached (e.g., child abuse, elder abuse, danger to self/others). Permission would need to be granted from the IRB entities to release any information.

Protections for Confidential Data. The audio tapes, paper documents (demographic data sheets, consent forms, debriefing forms, and transcripts) are kept in a locked cabinet in a locked office. I will store electronic Word and Excel documents (transcripts, journal, reports) on a jump drive that are also kept in the locked cabinet in a locked office. I kept the master code sheet in a separate locked cabinet in a locked office. I am the only individual who will have the ability to link participants to the study, and I will not provide this information to anyone. I will destroy all raw study data 5 years following dissertation publication, pursuant to compliance with the Walden University guidelines. I will use privacy envelopes to transfer all data.

Incentives. I offered no incentives to participants.

Summary

I outlined the research design and rationale for performing the study, sampling procedures, questions asked of the participants, and procedures to protect the confidentiality and rights of participants. I provided descriptions of data collection, analysis, and interpretation. This methodology chapter will be followed by the findings of the study in Chapter 4 and conclusions of the study in Chapter 5.

Chapter 4: Results

Introduction

The purpose of this hermeneutic phenomenological, qualitative study was to gather an in-depth understanding of the lived experiences of male batterers participating in a standardized Duluth-model batterers' treatment group. One overall research question was formulated in an attempt to understand batterer's treatment from the batterers themselves. The research question that guided the study was, what is the experience of a male batterer participating in a standardized male batterers' treatment program based on the Duluth model?

The interview questions were formulated as open-ended questions with an emphasis on the batterer as the expert or holder of the knowledge. These questions allowed batterers to provide rich descriptions of the group experience without having to identify as batterers. In Chapter 3, I reviewed the research methodology, the appropriateness of the research design, the steps taken to assure ethics in this research, and the qualitative approach taken for this study. I included the recruitment methods, sampling strategy, and number of participants in Chapter 3. I also described in detail the analysis plan for the study. In Chapter 4, I restate the research question and methodology to provide detailed results of the study along with the study findings.

The setting of the study was Lutheran Social Services in Minot, North Dakota. The Walden University Institutional Review Board (IRB) approved the study (#12-28-15-0317719). In addition, I obtained IRB approval from my employer, Minot State University (#1521) and a letter of cooperation from Lutheran Social Services (Appendix D). Participation in the study was completely voluntary to avoid any conflict of interest. I

placed no undue influence on participants that may have influenced the results of this study. I anticipated recruiting participants from the treatment groups and conducted no recruitment prior to IRB approval.

Sampling Strategy

Nine men participated in this qualitative study. I used purposeful sampling to recruit individuals who met inclusion criteria for participation. Criteria for inclusion included being a current batterers' treatment-group participant and being available for two interviews. I used fictitious names and ID codes (see Appendix G) to protect the identity of all participants. I gave participants a copy of the signed consent form with my contact information for further follow up, if requested. As outlined in Chapter 3, I conducted interviews in accordance with the methodology.

Setting

The research was conducted at Lutheran Social Services, a nonprofit agency. Participants had the option to complete the interviews at a time that was convenient for them before or after group in a private, confidential office onsite. All nine participants chose to be interviewed prior to the group sessions beginning. Participants also could have a facilitator join them during the interviews if they chose; however; none of the participants chose this option. The interviews were all completed in the same small conference room located off of the main meeting area that was used for the treatment group each week.

Pilot Study

I conducted a pilot study that consisted of the first two interviews and served as the preliminary study. I intended the pilot study to test the instruments used for data

collection, identify technical issues affecting data collection, and gain experience of conducting interviews with group participants. Pilot-study participants were from the same batterers' treatment group intended for the main study.

I inquired about the clarity of the language used in the data-collection instruments. Participants indicated that the forms (i.e., consent form, demographic-data form, and debrief form) were easy to understand and no changes were necessary. I tested the quality of the audio recordings during the first interview, which revealed no problems.

The hermeneutic phenomenological approach emphasizes the interaction of the researcher with the participant and the participant's words (Finlay, 2009; McConnell-Henry et al., 2009). Thus, the first two participants provided me with a first-hand experience of using a conversational approach while also gathering data related to the phenomenon of a batterer's treatment. I asked open-ended questions regarding each batterer's treatment based on the Duluth model. I kept journal notes to reflect my thoughts that occurred during and after the two interviews. I conducted the member-check process with the two participants and established credibility (Janesick, 2011; Miles & Huberman, 1994). The member-check interview allowed each participant to read through his transcript and confirm that the text reflected the discussion as audio-taped, discuss salient responses, and modify the information if needed.

In sum, I found the pilot study helped test the research design and instruments. The pilot study allowed me to understand methodological issues related to conducting phenomenological research. In addition, the pilot study offered me reflexive insights to inform and enhance the main study.

Data Collection

I collected data in an interview format using a series of open-ended questions. I formulated the questions to allow for thick, rich experiences of a batterer's treatment to emerge. I began each interview by asking the participant if they wanted to ask me anything or share with me before we began the actual interview. This approach was to engage participants and helped to develop rapport. I recorded each participant interview with a digital recorder. Interviews lasted from 40 to 75 minutes. The recordings began with the first interview question, after I presented participants with the nature of the study. Participants had the ability to discontinue the interview at any time. During the interview, additional clarifying questions assured I understood the information provided by the participants.

The semi structured interview protocol (see Appendix E) allowed for open-ended questions to seek answers to the research question. I asked some questions or sub questions out of sequence to allow the participant to naturally lead the interview. I paid close attention to the shifts in rhythm and tone of voice of participants to probe deep reflection. At the end of each interview, I set up a follow-up meeting with each participant to review their transcripts and assure the transcripts were an accurate representation of the participant's thoughts and experiences.

Interviews took place over a 3-week period. I transcribed all data verbatim into a word document for review within 2 weeks of the interview. I provided each participant a summary of the transcript as well as the major themes that emerged from the data. Each participant found the summaries to be an accurate representation of the interview.

Each recorded interview is maintained on a locked jump drive kept in a locked cabinet. All consent forms, hard copies of transcripts, and demographic information are stored in a secured locked area and will be maintained for a 5-year period, aligned with IRB requirements. The process did not vary from that proposed, from the pilot study, or from any unusual circumstances presented in the data collection.

Demographic Profiles

The study sample consisted of nine adult men. Seven identified as White, one as American Indian, and one as Hispanic. All participants were participants in the batterers' treatment program, thus were identified as batterers. Their mean age was 36.8 (SD = 6.7). The youngest participants were 29 years of age whereas the oldest participant was 48 years old, which represents a spread of 19 years. To allow for the individual voices of each participant to be heard, following is a brief description of each participant.

Charles: He was a man of few words yet when he spoke, he provided rich knowledge. He was able to provide a thick, rich description of not only his own life experiences, but also what his lived experience was like in the treatment group. He also provided valuable input into what a treatment group needs to enable participants to learn and grow.

Frank: He appeared to be a quiet, yet compassionate man who identified the group as a type of supportive environment where he could reflect. He appeared eager to learn new skills while at the same time indicated that the group was falling short of providing new skills to him.

George: He appeared to be an open and honest man who was willing to share his own previous experiences with different treatment modalities, enabling him to provide a

more eclectic narrative. He was able to provide valuable knowledge regarding not only the treatment, but the method in which it was delivered. George was one of the newest additions to the group thus he was able to provide a different perspective then some of the more experienced group members.

Joe: Joe appeared to be a reflective participant who provided a holistic narrative of his experiences in group and throughout his own life personally and professionally. He provided a rich description of his personal growth throughout his process as a participant.

Lewis: Lewis provided a thick, rich description of ways to improve the current treatment modality. He was a very articulate man who was optimistic about the model and ways it could be delivered more effectively. He was a vocal man who had experienced other group treatment modalities, thereby adding to his breadth of knowledge.

Luke: He was considered one of the most knowledgeable participants due to his close proximity to completion of the treatment program. Luke was able to provide a rich, encompassing narrative of the group and how it has changed him over time. He was a reflective and introspective participant. Luke has been a group member for over two years due to his work schedule thus he had extensive knowledge of the group.

Michael: Michael was able to provide a detailed narrative of his experiences. He was an articulate man who vocalized not only his experience as a participant, but provided insight into the impact it had on his overall life. He also provided valuable suggestions for improving treatment delivery. Michael was easy to engage and he laughed periodically throughout the interviews.

Tim: Tim appeared to be a humble man who was searching for ways to become a better husband, employee and friend. He provided a rich narrative of ways to improve treatment delivery. Tim vocalized the significant impact that societal expectations had on his own understanding of relationships.

Tom: He was a man of very few words yet each time he spoke he provided a detailed and descriptive response. Tom provided honest and emotional responses that were marked with a strong desire to improve treatment. Tom enjoyed using humor to convey his message during the interviews.

Participants' educational attainment varied, with 67% of participants reporting they are high school graduates whereas 22% of participants reported some college and 11% indicated some high school. All nine participants identified their primary source of income as their employment; however, one participant was incarcerated during the study and thus lost his primary source of income.

Participants reported their current marital status as married (55%), as divorced (11%), single (11%), and living with a partner (22%). The majority of participants, 88%, had children, with only one participant indicating he had no children: 22% had one child, 44% had two children, and 22% had three children. Study participants provided evidence that domestic violence impacts families across socioeconomic and cultural lines, evidencing the significance of a major public health problem (Adelman & Correa de Azevedo, 2011; Brown, 2008; Chan & Cho, 2010; Hague & Sardinha, 2010; Kanno & Newhill, 2009; Kruse et al., 2011; Stith et al., 2011). See Table 2 for the full demographic information gathered about the participants.

Table 2

Demographic Characteristics of Study Participants (N = 9)

Demographic characteristics	*N*	%
Age *(M, SD*)	36.8	6.7
18–35 years	4	44
34–45 years	4	44
44–55 years	1	11
Ethnicity		
American Indian	1	11
Hispanic	1	11
White	7	78
Educational attainment		
Some high school	1	11
High school diploma	6	67
Some college	2	22
Primary income source		
My employment	9	100
Current martial status		
Single	1	11
Married	5	56
Divorced	1	11
Living with partner	2	22
Number of children *(M, SD)*	2	.76
No children	1	11
1–2 children	6	67
3–4 children	2	22

Data Analysis

A hermeneutic phenomenological design enables the exploration of experiential data through identification of themes in response to research questions (Finlay, 2009;

McConnell-Henry et al., 2009). The following steps assisted in the process of discovering themes.

Step 1: Listening and Reading

The initial analysis procedure included listening and relistening to the recordings of each participant's responses as they related to the research questions. During the manual-transcription process, ideas about data began to emerge. I read my field notes from the interviews and placed them in the body of the interview texts. In addition, I read each full transcript while listening to the audio-tape to embed emotional content to the transcripts.

Step 2: Physical Manipulation of the Text

The next step was to identify significant statements in the transcripts. This step involved physically manipulating the data using a variety of different methods. Initially, I identified statements with similar meanings with different colored highlighter pens. In addition, I integrated field note entries reflecting my thoughts on the data. I used NVivo 10 to assist in the organization of the data, entering the transcripts to allow for a more thorough review and to assist in coding.

Step 3: Coding

Coding is a qualitative research technique used to organize data into categories and themes that enables a researcher to use inductive reasoning (Creswell, 2013). Codes are labels that assign symbolic meaning to the descriptive information compiled in a study (Miles, Huberman, & Saldana, 2014). Through the use of NVivo 10, researchers can manually code the data and analyze words (seek word frequency/repetition) and make comparisons. In addition, I sought word trees, metaphors and analogies.

Step 4: Identifying Themes

Although the first three steps of data analysis involved line-by-line interpretations, the fourth step involved the development of code clusters into headings that represented similar themes across the entire data set. NVivo 10 visually compiled the code clusters and headings. I then combined the code clusters and headings to represent the emerging themes.

Data-Analysis Findings

In this study, I sought to present the voices of batterers as they shared their experiences with a standardized batterers' treatment program based on the Duluth model, using emergent themes from the analysis of all participants to answer the research questions at the same time. Open-ended questions focused attention on gathering data that led to an intimate understanding of the experience (Creswell, 2013). The cross-case analysis of the data yielded three major themes related to the overall research question: (a) overall group experience, (b) facilitator's role, and (c) the Duluth model. In this study, all themes had the same level of importance, as each contributed to the overall understanding of the phenomena. Following are the themes and subthemes that emerged related to the experience; 1) overall group experience, 2) facilitators, 3) Duluth model. Participant interview statements support the themes and subthemes.

Theme 1: Overall Group Experience

The first overall theme that emerged from participants' narratives was the overall group experience. All participants discussed their individual experiences as a group member of a male batterers' treatment group. From this group experience, four

subthemes emerged: (a) punishment, (b) victimization, (c) acceptance, and (d) instructional tools/delivery.

Subtheme 1: Punishment. Seven of the nine participants reported they felt the group experience was punitive. Participants indicated that much of each session focused on highlighting what participants did wrong in their interpersonal lives. Participants reported each session typically began with a video highlighting the male as the aggressor and the female as the victim. The seven participants indicated that this group experience created a sense of punishment, exemplified in the following statements.

Tom: It kind of felt like it was a judgment to all men.

Michael: I just feel like I am scolded for an hour, and how bad, bad, bad I am. I am a terrible person. In any fight you know it takes two to tango. It's simply not how it is. It's plain and simple and I feel, especially in the domestic situation, both of us should've been put in this class.

Frank: So I don't know so much if I am learning anything different as much as I am being punished. It's demeaning.

Charles: They just basically persecute us because we got in trouble for what happened, and the other person didn't.

Subtheme 2: Victimization. All participants in the study identified themselves as victims in their intimate relationships. The theme of victimization arose in each interview spontaneously with all participants identifying themselves as victims. Each participant stated that his partner had engaged in unhealthy relationship practices that were not addressed in the group process. Some participants' thoughts are exemplified in the following significant statements:

George: Someone might be off their rocker, they are coming at you crazy, how do you reason with that? She started throwing things at me.

Lewis: Those feelings started turning to anger and resentment because she had not returned my call, she was not returning my call; she would not let me know she was okay. When she walked in the door after 45 minutes she was on the phone with her sister and I just lost it and I thought she didn't care about me.

Michael: In any fight it takes two, it's plain and simple, and I am in this class because I am the problem and she doesn't have to think about it again.

Charles: My victim was trying to kill me with her car and she tried to back up and run me over. I was just trying to get away from her.

Subtheme 3: Acceptance. Eight of the nine participants did identify and acknowledge their actions that necessitated the need for participation in batterers' treatment. Many participants acknowledged they could improve their communication with their partner as well as their responses to frustration or anger. Participants acknowledged their behavior, highlighted by the following statements:

Joe: I have had control problems and stuff like that.

Frank: I have learned what I have done in the past like how I have maybe manipulated people and stuff like that. I did not realize the extent.

Charles: I grew up in an abusive family; it was kind of like a learned trait for me.

George: I know I should not have pulled her on the bed.

Tim: I knew I needed to do, a way to channel anger, and I have been to different therapies.

Luke: I was the guy in the corner saying it was the alcohol that made me do it and blamed everyone else except myself. Didn't take long for me to realize I had to suck it up and admit it was my fault.

Lewis: I realized I had to make a lot of changes; starting the course from that perspective was really important. I really had to want to learn and grow and become something better than I was. I'm here now because of experiences 10 years ago in which I made some pretty poor choices.

Michael: I am not going to portray myself as perfect because I'm not. I had my own run ins with the law over the years. In any fight, you know it takes two to tango. I will admit my part, so I am not saying I shouldn't be here.

Subtheme 4: Instructional tools/delivery. All nine participants' narratives highlighted an overly simplistic delivery of the model. Participants indicated that the videos shown at the beginning of each session are one sided and only show the explosive element of the situation without showing precipitating factors. Participants' narratives further highlighted the lack of skill development they received due to the reactionary approach of delivery. Participants' thoughts regarding the delivery and tools used in the group are exemplified in the following statements:

George: I feel like a lot of these programs are too focused on what you did wrong and what you're doing wrong. They don't leave me feeling like I learned how to be better.

Lewis: You know when I came here, I had hoped that I could walk away with a little bit of encouragement and hope as to what I can do better. We watch

videos in here. They make you feel terrible, and they don't leave me feeling like I have learned anything.

Charles: They just basically persecute us because we got in trouble for what happened. … I hear it is supposed to teach you a violence-free life, okay, but I mean from what they have been saying it sounds like they are saying in order for it to work we have to let people walk all over us.

Michael: You know these videos they show you, they always are one-sided in the video. They look one sided really bad. It's simply not how it is. It's plain and simple and I feel, especially in the domestic situation, both of us should've been put in this class.

Tom: It seemed like it was always presented to us like one sided. Like we were always the ones who were wrong.

Tim: In my opinion, they are telling us a lot of "your action was this so her reaction was that" and I am not worried about that, I am worried about me.

Frank: I have not necessarily learned what to do when my anger is building up or what I am supposed to do but I have learned what I have done in the past.

Summary. Eight of the nine participants identified themselves as having challenges in their intimate partner relationships, thereby suggesting that on some level participants believed they could benefit from the group. Despite this acknowledgement, seven of the nine participants indicated that shame and disempowerment marked the overall group experience. In addition, three participants specifically spoke about the videos used as a part of the curriculum as only further punishing and shaming them, rather than aiding them.

Theme 2: Facilitators

Seven of the nine participants identified the important role of the facilitators in the group. Participants indicated that both the male and female facilitators created a comfortable atmosphere for the treatment group. In addition, facilitators allowed conversations to be led by group members, creating a sense of ownership in the group experience. The following statements highlight participants' thoughts about the facilitators:

> Lewis: The facilitators are humble. They care about what they are doing and, more importantly, the people they are working with. They appreciate what you are saying and your feedback.
>
> Michael: It was very comfortable talking with them.
>
> Luke: I really get along well with the one male facilitator; he is someone I really look up to. He made it a whole lot easier.
>
> George: These guys keep the topics pretty down to earth and the subjects are good. The guy is pretty cool.

Some participants identified specific feelings regarding the female facilitator. Michael identified that having only one woman in the group was not beneficial as he believed she was not able to freely give her opinion. In addition, George identified he would experience more comfort in sharing thoughts and feelings if there were only men in the group. Every participant identified the current female facilitator as a good facilitator, despite their beliefs regarding the overall treatment experience.

Summary. Seven of the nine participants made significant statements about the critical role facilitators play in the group process. Although two of the seven participants

indicated having only one woman in the group, particularly in the facilitator role, was somewhat problematic, they both still indicated that the current female facilitator was a good facilitator. The seven participants clearly highlighted the emergent theme of the essential role of facilitators.

Theme 3: Duluth Model

As previously indicated in Chapters 2 and 3, the Duluth model is the standardized model used for male batterers' treatment. The model comprises eight categories: (a) intimidation, (b) economic abuse, (c) emotional abuse, (d) coercion/threats, (e) isolation, (f) male privilege, (g) minimizing/blaming/denying, and (h) children. Three subthemes emerged from participants' narratives: (a) appropriateness of the model, (b) treatment length, and (c) missing element of the model.

Subtheme 1: Appropriate. Eight of the nine participants opined that the overall Duluth model was a good one, and that the eight categories are appropriate for the model. Some participants identified certain categories as being of more benefit to them than others; however, overall, participants did not indicate any significant problems with Duluth-model categories. I verbally reminded each participant of the eight categories and the following statements highlighted their thoughts:

> Frank: I think they are all good. … I can put all of those things into my own life.
>
> Charles: Those ones are alright; I think they are okay.
>
> Lewis: I think a lot of the categories are good. There's a lot of things that, regardless of your position, and those things are all pretty applicable.
>
> Tim: They need to be there; I think all of those things need to be in there.

The participants did vary on specific categories, indicating some categories were more relevant than others. Two of the nine participants identified the category of minimizing/blaming/denying as especially relevant, exemplified in these statements:

George: Minimizing the situation, you should probably already know that one as that is why you are here, lost your temper or whatever.

Luke: I think the one that has stuck with me the most is minimizing/blaming/denying. I mean I have doing this for a little while, I can look back and see where I was when I first started.

Two participants found the category of economic abuse relevant. Participants' thoughts are exemplified by the following statements:

George: Economic you mean money wise? Everybody fights about money, everybody does. Both people are going at each other about money, it is better to talk about it.

Tom: I really liked going over the economic one as that one actually does cause a lot of complications in relationships.

One participant recalled his thoughts on several categories, explained in this statement:

Joe: Well I know about intimidation and stuff, I remember that one because we watched a video on it. I, during the video, reflected back on times when I would take the upper hand right away. When you see it from the outside looking in, it kind of shuts you down and makes you actually see what it might look like and how I might come across as a scary person. Emotional abuse that has been a big one, putting someone down or not giving

compliments or something like that. Threats, threats have been an issue in the past. In a general sense, all of these, this has class had made me look at everything from a different point of view because actually seeing a video or seeing it happen you almost feel as if, feeling like a victim. I have done it before and I would not like someone to yell at me or belittle me.

Eight of the nine participants were parents and one participant indicated he did not believe that children as a category needed to be addressed. In addition, one participant indicated a strong dislike for the discussions related to sexual respect, stating the following:

Charles: We spend a couple weeks talking about sexual respect, these **** they talk like we go around raping **** and ****. I mean it was like, we're kind of pissed off now. They basically made us sound like a bunch of sex offenders, okay, and I don't like that because I don't like sex offenders.

Subtheme 2: Treatment length. The Duluth model is 26 weeks in duration and thus four of the participants shared thoughts on the length of time required for completion of the treatment. The following statements highlight participants' thoughts:

Lewis: In some other places the group is 52 weeks; we are lucky that it is only 26 weeks here.

George: I think 26 weeks is too long. I mean we are here for a reason but I think it could be accomplished in a shorter period of time. Instead of 26 maybe 14 to 16 to give some flexibility.

Joe: In a general sense, it does get long, the 26 weeks, but in order for it to have an impact it has to be a longer length of time. We are all here for a reason.

Tom: I think it would be easier if we actually met more than once a week, like two times per week and cut the time in half.

Two participants identified the significant impact that 26 weeks of treatment had on their lives, exemplified in the following statements:

Michael: 26 weeks, that is why it feels more like a punishment. Wait, no, it is 27 weeks because you have orientation first. I have to leave work early every Tuesday, right, to be here. You know, I don't think that the boss is happy about it all. So for so many months I had it all set up and then they decide one week that we have no say about different times. We are criminals so we don't get a say. It becomes more frustrating.

Tim: It would be different if you only have to make the commitment for a couple of weeks, but when you're looking at 26 weeks, it turns into a long lime and it can be hardship for people with jobs and families in different obligations. I missed one week because of work. I work in **** and am a receiving guy. I don't and can't control when the truck comes in. Nor everyone works 9–5 jobs. we work construction, seasonal and hourly, and we can't just leave and still have our jobs.

Subtheme 3: Missing element. Five of the nine participants indicated that the design of the Duluth model, which focuses only on the male in the relationship, was problematic. All five participants indicated the lack of attention to the woman's contribution to the situation was detrimental to the overall success of the Duluth model. Participants each identified different ways to address this deficit in the model. Tom indicated that the woman should come into one treatment session to show a one-on-one

interaction with their significant other. Michael indicated that the women should have to attend group as well. Two participants indicated that the group should be comprised of both men and women.

> Tim: I actually think it would help. You would get a different perspective so if you say "this is what she always says" you could get a different female perspective and she might say "from my perspective this is what I see happening."
>
> George: Having mixed gender groups, it could be more of a growing experience for both people in the group.

Three of the nine participants shared thoughts on having only one woman in the group, particularly in a facilitator role. The three participants indicated that having one woman created a barrier to the treatment.

> Michael: It should have more female input. It's always a group of guys; the only female input we have is the one facilitator. This is nice but she's the only one, the only voice. I think some victims of the real battering, real cases of women, come in and talk with us and help us all.
>
> Lewis: I feel like **** hands are tied because she's the instructor and she's trained to only provide the professional side of things.
>
> George: It just seems like the female takes the female side every time. I mean I think men should be with men; when women are around they might take something we say the wrong way. We are not meaning it to be wrong. I respect women and everything but I think in a situation like this, it would

be better for male-on-male counselors. You could be more open about things.

Summary. The emergent theme of model appropriateness arose individually and collectively from participants. Eight of the nine participants identified the eight categories of the Duluth model as appropriate to the treatment, whereas two participants identified the category of economic abuse as of particular significance to them individually, although they did not negate the benefit of the other seven categories. In addition, two participants identified the significance of minimizing/blaming/denying. Only one participant found the category of sexual abuse particularly offensive and suggested the category be removed from the model.

The length of the Duluth model, 26 weeks, is a significant amount of time and participants did not appear to have consensus about whether the length was appropriate. Two participants indicated that the length of time was of particular concern to their employment situations. The theme of treatment impact on participants' lives emerged from the narratives.

Five of the nine participants suggested that a missing component from the Duluth model was the lack of treatment for participants' partners. Participants identified that the Duluth model could be enhanced if it included the partner in some capacity. Two participants suggested that the treatment group include women with three participants suggesting that the Duluth model batterers' group only be comprised of men, with a separate group for women. The common theme among the five participants was that their female partners should be involved in some sort of parallel Duluth-model programming.

Discrepant Case

Luke was the one significant discrepant case, as he has been participating in the treatment group since 2012. Although the treatment group length is 26 weeks, Luke has had to start over multiple times due to his work requirements of traveling and thus being unable to attend regularly. Luke's extended length of time in the group allowed him to hear the information multiple times as well as engage with multiple other participants throughout his own group process. I included Luke's interview in the data analysis as he identified themes that mimicked those of other participants. Luke is one of the individuals who identified the group as beneficial, which is reflected in the following statement:

> Luke: Looking all the way through it, it was definitely beneficial, yes it was. I was still making poor decisions, was behaving and reacting to situations and sill wasn't using what I had been shown, using those tools, productively.

Trustworthiness

The issue of trustworthiness is a combination of not only the methods of fieldwork, but also the transparency of the researcher (Patton, 2002). According to Williams and Morrow (2009), researchers must attend to the credibility of the data, reflexivity/subjectivity, and honest communication of findings. Credibility was established by clearly identifying and following rigorous procedures for data collection and data analysis. I audio-recorded each interview and then transcribed each interview verbatim, which allowed for immersion in the data and experiences of the participants. This process also allowed for accuracy of the data. According to Patton (2002) and Creswell (2013), member checking is imperative in assuring the credibility of data. I reviewed transcripts with each participant and made no changes to the transcripts, but the

multiple contacts with each participant were intended to create trust and transparency with me, as the researcher. I used direct quotations when appropriate to convey the thoughts and feelings of participants, ensuring integrity of the data (Williams & Morrow, 2009).

I coded each interview separately to allow individual themes and meanings to emerge. Through the process of individually coding each interview, coupled with listening to each audio-taped interview and rereading transcripts, it became apparent that similar thoughts, feelings, and experiences could fit into categories that evolved into similar themes. Use of NVivo software assured consistency and accuracy of the data. NVivo software allowed for visual representation of the data, which aided in data analysis and enhanced validity of the findings.

Participants conveyed their experiences through their own words and descriptions, which allowed for the thick, rich descriptions of participants' lived experiences to be uncovered. Thick, rich descriptions are essential to the credibility of qualitative inquiry (Patton, 2002). I used direct quotations, when possible, to achieve transferability in the data. Dependability was achieved through the establishment of an audit trail that included nine audio-taped interviews, nine transcripts, an interview guide, nine debriefing forms, and one contact sheet. A balance of reflexivity and subjectivity emerged through positioning participants' narratives in the context of the overall research question (Williams & Morrow, 2009).

Reflecting on my role throughout the study established confirmability. As a woman who has worked in the field of domestic violence for nearly 20 years in a wide variety of roles, I had to acknowledge the impact these experiences brought to the study. I

realized throughout the study that these participants were much like other individuals with whom I have worked in a therapeutic capacity and simply wanted to be heard. I realized that despite my previous work with victims, what participants sought was to truly be heard, much like the victims I have worked with in the past. As Williams and Morrow (2009) indicated, clearly communicating the findings while still incorporating the subjectivity that brought to the study is essential in establishing trustworthiness.

Summary

This chapter has provided an account of a hermeneutic phenomenological analysis aimed at understanding the lived experience of male batterers participating in a standardized Duluth-model-based treatment program. The study had one overall research question that guided the four basic interview questions provided to each participant. From the individual interviews with group participants, three general themes emerged. The first theme was the overall group experience. Participants identified the overall group experience as disempowering, marked by shame and punishment. The perception of the participants was that the group's focus was overly simplistic, did not include precipitating factors, and did not instill hope for change.

The second theme that emerged was the significant impact that the facilitators have on the group experience. Participants spoke positively about the facilitators and the skills they brought to the group experience, including creating an engaging and welcoming environment in which their opinion mattered. The participants were divided on whether there should be both a male and female facilitator, as two participants believed that only having one woman in the group, in a facilitator role, was problematic to the group process. Two participants indicated they would prefer the group have only

men; they both identified that the current female facilitator was engaging and doing an adequate job.

The third theme was the participant's thoughts on the Duluth model and its eight related themes. All participants identified the overall Duluth model as an appropriate model for the treatment. Two participants found significant benefit in the economic-abuse category whereas two participants noted that the category of minimizing/blaming/denying was of particular benefit to them. In addition, the Duluth model's length of 26 weeks did not appear to be problematic for the majority of participants; however, two participants specifically identified the financial impact that the length of treatment had on them, due to needing to miss work.

Overall, participants identified that the Duluth model in itself was an appropriate model; however, participants identified that the current batterers' treatment was not working. The participants identified feeling punished and disempowered in the group while simultaneously identifying themselves as victims. Participants all spoke positively about the current facilitators of the group, despite believing the current program was not working for them.

In Chapter 5, I will present, discuss, and evaluate the findings from the study. The study will be placed in the current body of literature. In addition, I will review the limitations of the study. Finally, I will present implications for positive social change from the study and suggestions for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of the study was to explore the perceptions of male batterers currently participating in a standardized Duluth model batterers' treatment program about their treatment experiences. The batterers were participating in the Duluth model treatment program through Lutheran Social Services in Minot, North Dakota. Results showed that overall, participants believed the Duluth model, as a treatment program, contained eight appropriate themes (isolation, intimidation, coercion/threats, economic abuse, emotional abuse, male privilege, minimizing, and children). Study participants further indicated they found the facilitators to be an essential component of the treatment program. All nine participants identified that the current delivery of the Duluth model was ineffective because of the negative delivery style.

Specifically, study participants indicated that the delivery of the Duluth model was marked by punishment, shame, and disempowerment. Results indicated that participants found the delivery method to be solely focused on the explosion of anger (physical violence) of the intimate-partner relationship without regard to precipitating or contributing factors. Results provided evidence that participants experienced a sense of hopelessness in the treatment program. All nine participants identified feeling hopeless due to the focus being on the participant's errors in their intimate partnerships without regard for what their female partners may have contributed.

The role of facilitators proved to be an essential component to treatment-program participants. Results provided evidence that facilitators influenced not only the tone of the group but the comfort level of participants as well. Participants spoke positively about

the two facilitators. In addition, three participants discussed the positive feelings they experienced as a result of the two facilitators; other participants identified a bond with the male facilitator. Results provided evidence that participants believed in the Duluth model as a treatment program. Overall, participants spoke positively about the eight themes of the Duluth model and believed it could be an effective treatment model for batterers.

As stated in the Chapter 2 literature-review section, a preliminary review of extant studies showed that the Duluth model is the most commonly used court-sanctioned treatment for male batterers in the United States and Canada (Corvo et al., 2009), yet long-term research of the model has continued to demonstrate little or no efficacy and high recidivism rates (Aymer, 2008; Babcock et al., 2004; Corvo et al., 2009; Herman, Rotunda, Williamson, & Vodanovich, 2014; Huss et al., 2006). Results from this research added an essential component to the existing body of literature: the voice of the batterers themselves. In addition, the voices of the batterers provides evidence that the Duluth model may be an effective treatment model for male batterers. The following discussion reviews the findings from the results described in Chapter 4 and compares those results to previous research found in the peer-reviewed literature described in Chapter 2.

Interpretation of the Findings

Research into the effectiveness of batterer's treatment, typically psychoeducational in nature, has proven ineffective over the short and long term (Arias et al., 2013; Aymer, 2008; Corvo et al., 2008; Corvo et al., 2009; Huss et al., 2006). Results from participants supported previous findings that the current treatment programming is ineffective. Participants were participating in the standardized Duluth model, which is the most common form of standardized treatment offered to batterers (Arias et al., 2013;

Levesque et al., 2008). Although results from participants indicated that the current Duluth model was not working, evidence suggested it was not the model itself that was problematic but the delivery of the model.

The Duluth model is intended to be delivered in a confrontational manner to confront ambivalence; however, participants indicated this delivery style incited feelings of shame and disempowerment, thereby raising participants' defenses. Although the intent of the confrontational delivery style is to address ambivalence and hold batterers accountable, it appears this approach is proving counterproductive. According to Eisikovits and Bailey (2011), the confrontational style of the Duluth model was used to transform men into nonviolent partners; however; participants experienced such high levels of disempowerment that they were unable/unwilling to even attempt positive change. The belief that one has the ability to change and the tools needed are essential in a participant's treatment-outcome expectancies (Meis, Murphy, & Winters, 2010). Participants' results indicated that the confrontational approach did not motivate them to change; rather it created defensiveness and a closed stance. According to Meis et al. (2010) most batterers are in the contemplative stage of change when they begin treatment, which was found in the present study as well. This finding suggests that group facilitators must promote an environment that elicits positive change (Meis et al., 2010). Although participants perceived the group experience to be ineffective, participants indicated that the facilitators played a critical role in the treatment program.

Participants highlighted the role of the facilitator as an essential component of batterers' treatment. Participant's identified that facilitators set the tone for the treatment and directed the conversations. Participants identified that the current facilitators created

a comfortable setting for treatment. Group facilitators play a pivotal role in not only treatment engagement but successful treatment outcomes for participants (O'Sullivan, Blatch, & Toh, 2014). Strict adherence to manuals, confrontation, and authoritarianism by group facilitators deters participants' engagement and success in treatment (O'Sullivan et al., 2014). Current findings were consistent with O'Sullivan et al. (2014), suggesting that the current Duluth model's confrontational approach is ineffective. Participants reiterated the O'Sullivan et al. caution against a universal methodology, suggesting that the current Duluth model's confrontational approach is ineffective. Furthermore, O'Sullivan et al. suggested group facilitators undergo extensive training including experiential exercises to increase group effectiveness.

King (2009) and Kolb and Kolb (2009) described the value of experiential learning, adding that it increases practitioners' competence. The issue of experiential learning for group facilitators appears to be of particular relevance to batterers' treatment due to high-recidivism rates, court-ordered mandates, and the complexity of domestic violence. Demands on therapists in mental health services have continued to increase in complexity and intensity, thereby necessitating advanced training and ongoing learning opportunities (King, 2009). King and Muldoon and Gary (2011) identified the danger that exists when undertrained or insufficiently trained providers attempt to provide services to clients. The present study's findings suggest that group facilitators are an essential component of batterers' treatment, and knowledgeable, competent, trained, and skilled facilitators should deliver the model to assure success for participants and the overall efficacy of the treatment program.

As previously mentioned, the Duluth model has failed to demonstrate efficacy; however the present study findings suggested that the actual Duluth model and corresponding eight central themes are appropriate for a treatment program. Participants were all reminded of the eight themes and several spoke positively about the themes. Participants further identified the applicability of the themes to not only their intimate relationships but other relationships in their lives, suggesting the positive skill development the model may provide. Although Arias et al. (2013), Aymer (2008), Babcock et al. (2004), Corvo et al. (2008, 2009), and Huss et al. (2006) indicated the Duluth model was ineffective; current findings suggested this is not an accurate assessment. Rather, it appears that the way in which the model is implemented needs to be addressed. Findings suggested that the actual model may be effective if practitioners use a planned, purposive implementation of the model. Findings show that skilled practitioners must implement batterers' treatment who have an innate understanding of not only domestic violence but effective therapeutic skills.

In summary, the Duluth model has been the most used standardized treatment program for male batterers, despite what researchers have identified as an ineffective model. Findings from the present study suggested that the assumption that the Duluth model is ineffective may be misguided. Current findings suggested that the Duluth model may be an effective model for batterers' treatment; however, the way the model is implemented and by whom needs redefinition. It appears that having experienced, well-trained facilitators is essential due to their role in not only establishing treatment engagement, but group cohesion and change. In addition, a more strengths-based,

experiential model of implementation may not only enhance participant engagement, but successful completion of the treatment program.

Limitations of the Study

Limitations exist in the present study. The first factor limiting this study was using only one treatment group in Minot, North Dakota. Although not all participants were from the same area, they were all participating in the same treatment program at the same time, which may have influenced the findings. Findings may have been influenced by the sample size of this study. The study contained nine participants. Perhaps a sample size larger than 10 would have increased the diversity of the sample and provided a more substantial conclusion about the Duluth-model treatment program. Finally, the study may have been further enhanced if participants were interviewed following completion of the program, thereby providing a more cohesive sample.

Recommendations

As previously mentioned, additional studies in the other geographical locations in the State of North Dakota that provide a Duluth-model treatment program should be considered. Future researchers should include larger samples of treatment participants to expand on the findings from the present study. Future research should also include qualitative and quantitative approaches to add to the current body of knowledge. Further, additional research should include facilitators and administrators of Duluth-model treatment programs to provide a more holistic picture of the treatment. In addition, incorporating other races/ethnicities (i.e., Asian, African American, Hispanic, and Native American) may also be an area future researchers should explore, as the primary race of this study was White, by default. Studies aimed in these directions would provide critical

information to those tasked with developing and implementing treatment for male batterers.

As a recommendation for action, results from this study indicated that the Duluth model contains the appropriate skill set for an effective male batterers treatment program. Findings suggested that participants were not being provided the support to make the necessary changes in their lives. In addition, findings suggested that facilitators played a pivotal role in the treatment program. Therefore, the actions I recommend to improve the way the Duluth model is implemented include the following:

- Establish firm policies regarding specialized training of group facilitators that includes advanced clinical degrees and experiential work and training.
- Redesign the materials used in the Duluth model to include precipitating factors as well as proactive steps participants can take to avoid conflict.
- Include experiential work for participants to internalize the new concepts being taught.
- Include batterers, facilitators, and domestic-violence service providers in the strategic planning, development, and implementation of batterers' treatment programming to improve programming outcomes and reduce recidivism.
- Batterers treatment programs and domestic-violence victims' programs should work collaboratively with human service programs to assure consistent programming is offered to those in need of services.
- Disseminate current and future findings through conferences, presentations, and publications that target mental health providers, stakeholders, and policy

makers to enhance continued and collective efforts to eliminate domestic violence.

Implications for Social Change

Study results identified issues of great significance for mental health providers, policymakers, criminal justice personnel, and advocates involved in the domestic-violence field. Findings from this research showed that the Duluth model, from a batterer's perspective, may actually be a functional model for batterers' treatment. Findings further suggested that the role of the facilitator(s) is essential to the experience of group participants. In addition, findings showed that group participants need empowerment and encouragement to make positive relationship changes as well as opportunities to practice these new skills. These findings are of critical importance to those tasked with not only developing but implementing treatment programming for this specific population. Although this study was limited to domestic violence, batterers' treatment has the potential to expand to other high-recidivism populations including addicts, violent offenders, sexual offenders, or criminals. Findings may also be of benefit to mental health providers who provide group treatment services. Findings highlight the need for specialized, advanced training to meet the needs of complex clients.

Conclusion

The Duluth model remains the most commonly used treatment program for male batterers and findings from the present study suggest this model can be effective for male batterers' treatment. The present study provided critical information regarding the Duluth model; specifically, the eight themes of the model were deemed relevant by batterers themselves. Results from the study suggest that the delivery style of the Duluth model

must be redesigned from one of confrontation to one of empowerment. All participants identified feelings of shame, disempowerment, and hopelessness from the treatment. Despite the negative feelings the participants expressed, collectively participants believed the eight themes of the model were valid. In addition, results suggest that the facilitator(s) play an essential role from initial group engagement to process and change. The requirements and training of Duluth-model facilitators must be redesigned to ensure that competent practitioners are providing batterers' treatment. The method of delivery of the Duluth model must be redesigned to focus more on strengths and an evidence-based approach with experiential learning opportunities for participants. These changes will allow the Duluth model to not only be effectively implemented, but create positive, lasting change in participants who attend.

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Appendix A: Demographic Data Sheet

Interview #1 Only

ID number assigned to Interview_____ Date: ___/___/____

1. My current marital status:

   ___ Single

   ___ Married

   ___ Divorced

   ___ Legally separated

   ___ Widowed

   ___ Living with partner

2. Do you have children? ___ No ___ Yes If yes, how many? _____

3. The highest level of education I have is:

   ____ Below 8th grade

   ____ Some High School

   ____ High School Diploma

   ____ Trade or Technical Degree

   ____ Some College

   ____ College Graduate

   ____ Graduate or Professional Degree

4. My primary source of income is from:

___ My employment

___ SSI

___ Social Security

___ Public assistance

___ Family/Other

5. My age is: _____ years

6. My race is (You may mark more than one):

____ White

____ African American/Black

____ American Indian/Native Alaskan

____ Hispanic

____ Latino

____ Asian

____ Filipino

____ Other: _____

Appendix B: Letter of Invitation

Hello:
My name is Dionne Spooner, and I am a doctoral candidate at Walden University. I am inviting you to be a part of a study that will be developed in cooperation with the Male Batterers Treatment Group here at Lutheran Social Services. With this study, I would like to explore, with you, your perceptions about the current treatment program for male batterers. You may find the study interesting in that you will have an opportunity to voice your opinion not only about the current treatment program, but what you believe should be incorporated into the program to increase its effectiveness. This study may help those that not only develop treatment programming, but those who administer it as well.

Your participation in this study is completely voluntary. You are free to refuse to participate, and if you choose to participate, you are still free to leave the study at any time without any negative consequences to your current treatment. Your decision to participate in this study will not affect your relationships with the individuals or services that you receive at Lutheran Social Services. If you do choose to participate in the study, you will meet with the researcher to discuss your thoughts, opinions, and feelings about the current batterer's treatment program.

If you participate in the study, you will complete two face-to-face interviews with the researcher in a private office at Lutheran Social Services. The first interview will take approximately 90 minutes. The second interview will occur approximately 3-4 weeks following the first interview, and will take approximately one hour. The interviews will be completed in English, so you must be comfortable reading and speaking English. The interviews will be audio-taped and transcribed with your permission and will be kept strictly confidential. This means that the researcher will be the only one who will have access to the audio-tapes, and they will be kept in a secure, locked box. The researcher will assign a confidential ID number to you so that your name is not identified on any research data collected, including written or the audio-tapes.

I thank you for your time and considering being a part of this study.
Sincerely,
Dionne L. Spooner
Ph.D. Candidate
Walden University

Appendix C: Consent Form

You are invited to take part in a research study regarding the current standardized Duluth model male batterers treatment program. The researcher is inviting any current treatment participant to participate in the study. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Dionne Spooner, who is a doctoral student at Walden University.

Background Information:
The purpose of this study is to examine the current male batterers treatment program from the prospective of those who are currently enrolled in the treatment. You are in a unique position to provide an invaluable, firsthand account of the current treatment and its components.

Procedures:
If you agree to be in this study, you will be asked to:

- Meet with the researcher for two interviews which will last approximately one to two hours each. You will be asked questions related to your experience within the current batterers treatment program.
- The interviews will be held on site in a privately assigned office.
- The interviews will be conducted in English. You will need to be comfortable communicating in English.
- Your interviews will be audio-recorded with your permission. All materials will be kept confidential, including the recordings and all written communication.
- Your identity will be kept confidential and anonymous through an assignment of a unique ID number.
- You will be asked to complete a demographic data sheet at the end of the interview. This document will be kept confidential as well.
- We will debrief you about the overall interview, and this will be documented through the study debriefing form. This document will be kept confidential.
- The second interview will be set up and will occur 3 to 4 weeks following the first interview.

Voluntary Nature of the Study:
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one at Lutheran Social Services will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as stress or becoming upset. Being in this study would not pose risk to your safety or wellbeing.
The benefits of participating in the study include allowing your voice to be heard regarding male batterers treatment and improving future male batterer's treatment.

Payment:
There is no payment or incentive being offered for participation in this study.

Confidentiality:
Any information you provide will be kept confidential and will not be released without your expressed written consent, except in the cases as required by law (child abuse, adult abuse). The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure by keeping it in a locked storage box. Data will be kept for a period of at least 5 years, as required by Walden University and American Psychological Association guidelines.

Contacts and Questions:
The researcher conducting this study is Dionne Spooner, Ph. D. candidate. The researcher's faculty advisor is Dr. Dorothy Scotten. You may ask any questions you have now. Or if you have questions later, you may contact the researcher via e-mail (dionne.spooner@waldenu.edu) or Dr. Scotten at Dorothy.scotten@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott, who is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is IRB will enter approval number here and it expires on IRB will enter expiration date.

Please keep this consent form for your records

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I consent that I am agreeing to the terms described above.

Printed Name of Participant

Date of consent

Participant's Signature

Researcher's Signature

Appendix D: Letter of Cooperation

Lutheran Social Services
Dennis Larkin

RE: Research Study

Date:

Dear Dionne Spooner,

Based on my review of your research proposal, I give permission for you to conduct the study entitled "An exploration of male batters perceptions of a standardized batters treatment program" within Lutheran Social Services. As part of this study, I authorize you to interview, collect data and sample 10 treatment participants. Individuals' participation will be voluntary and at their own discretion. I realize that this number may increase or decrease slightly depending on study participants and saturation of data.

We understand that our organization's responsibilities include providing access to the treatment participants, access to a secure room to hold the interviews and support the dissemination of the findings to us in a presentation. We reserve the right to withdraw from the study at any time if our circumstances change.

Dionne will be responsible for complying with our site's research policies and requirements, including obtaining IRB approval through our agency.

I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.

Sincerely,
Authorization Official
Contact Information

Walden University policy on electronic signatures: An electronic signature is just as valid as a written signature as long as both parties have agreed to conduct the transaction electronically. Electronic signatures are regulated by the Uniform Electronic Transactions Act. Electronic signatures are only valid when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Legally an "electronic signature" can be the person's typed name, their email address, or any other identifying marker. Walden University staff verify any electronic signatures that do not originate from a password-protected source (i.e., an email address officially on file with Walden).

Appendix E: Interview Guide

Interview Questions to explore perceptions about the Male Batterers Treatment Program

ID assigned to interviewee _____ Date: ____/____/____ Interview #1 & #2

Introducing yourself
D1. Tell me a little about yourself

Treatment

1. Describe for me the experience of a batterer in a male batterers treatment group?
2. What do you believe batterers treatment is intended to do for batterers?
3. Do you believe batterers treatment achieves its intended purpose? Why or Why not?
4. The current batterers treatment includes 8 central themes: intimidation, economic abuse, emotional abuse, coercion/threats, isolation, male privilege, denying/minimizing/blaming, and children. Explain to me your thoughts on these 8 central themes.

Closing

5. Is there anything else you want to share with me about the male batterers treatment program?

Thank you for taking the time to visit with me and share your thoughts on male batterers treatment.

Appendix F: Study Debriefing Form

For the study, entitled, "An exploration of male batters perceptions of a standardized batters treatment program", you were asked to participate in an audio-taped interview that would last about two hours, complete a demographic sheet, and participate in a debriefing about the study. You will be asked in this form to set a tentative date and time for a second shorter interview.

You were told that the purpose of the study was to examine the current male batterers treatment program from the prospective of those who are currently enrolled in the treatment. You are in a unique position to provide invaluable, firsthand account of the current treatment and its components. The actual purpose of the study was the same as the stated purpose.

I did tell you everything about the purpose of the study. If you have any questions, you may contact me, Dionne Spooner at dionne.spooner@waldenu.edu, or Dr. Dorothy Scotten at Dorothy.scotten@waldenu.edu.

If you want to talk privately about your rights as a participant, you can call the Walden University Research Participant Advocate who can discuss this with you at 1-800-925-3368 or by e-mail at irb@waldenu.edu.

You are aware that Lutheran Social Services does not offer crisis mental health services. If you have experiences of distress as a result of your participation in this study, the North Central Human Service center offers a 24-hour crisis hotline which is available to you. Please remember that any cost in seeking mental or medical health services is at your own expense.

You will receive a copy of this debriefing form from the researcher after the first interview. You will also receive a copy following the second interview.

Next Step: Visit again at Lutheran Social Services for approximately 30-45 minutes to review the researcher's interpretation of the interview. Approximately 3-4 weeks from today's date.

1. Next Meeting:

Date: _____ Time: _____

Thank you for your willingness to participate in this study, it is greatly appreciated.

Printed name of participant: _____ Date: _____

Participant's signature: _____

Researcher's signature: _____

2. Would you like to know the results and be kept informed about this research study?
   _____Yes _____No

   If yes, how can we contact you? _____ e-mail _____mail

   Best address or e-mail for notification of results:

   _____

   _____

Referral Information:

If you are in crisis and need support you may call the North Central Human Service Center at 857-8500 or 1-888-470-6968.

Appendix G: Master Code Sheet

Interviews

(This sheet is filed separate from all documentation)

Participant's Name (Real Name)	**Pseudonym Name**	**ID Number**